STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS	**1750 ROUTE 37 WEST** **TOMS RIVER, NJ 08757**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ141650, NJ142287 CENSUS: 74 SAMPLE SIZE: 3 F600 IJ Based on interviews, medical record (MR) review, and review of other pertinent facility documentation on 1/15/21, 1/20/21, and 1/27/21, it was determined that the facility failed to provide services necessary to prevent physical harm for a resident (Resident #2) with a known history and diagnosis of [redacted] [redacted]. On [redacted], Resident #2 became tearful and upset after a telephone conversation with the resident's family member. Resident #2 expressed to the Licensed Practical Nurse (LPN #1) at approximately 11:40 p.m. that the resident's family member did not want him/her to go home, and the resident was not sure if he/she wanted to live anymore. LPN #1 stayed with Resident #2 for approximately 5 minutes and then left Resident #2 alone. At 11:57 p.m., approximately 17 minutes later, while walking past the resident's room, the Certified Nursing Assistant (CNA #1) found Resident #2 hanging off the bed with [redacted] on the floor and yelled for the nurse. LPN #1 responded and found Resident #2 had the [redacted] his/her [redacted] times. The nurse removed [redacted] [redacted] Resident 2's [redacted] and placed the resident backdown into bed on the back. Resident #2 had [redacted]. The facility neglected to implement the care plan interventions to monitor for target behaviors,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/19/2021

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

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F 000	Continued From page 1 which included to monitor, document, and report to the Medical Doctor (MD) any ongoing signs and symptoms of [REDACTED] or comments. There was no documented evidence in the care plan that interventions were evaluated for their effectiveness. In addition, the facility neglected to provide [REDACTED] services for the resident, and the facility failed to provide all staff educational training for behavioral mood changes and [REDACTED]/prevention for a resident dealing with [REDACTED]. The facility also failed to follow its policies and procedures titled "[REDACTED]- Clinical Protocol," "[REDACTED] Threats," "Physician's Notification for Consultation," and "Behavior Assessment, Intervention and Monitoring." This placed Resident #2 and all other residents experiencing symptoms of [REDACTED] and the will not to live anymore at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 1/20/21 at 3:35 p.m. and reported to the Administrator and the Director of Nursing (DON). The Administrator and DON were presented with the IJ template that included information about the issue. The IJ was lifted on 1/20/21 at 5:09 p.m. when the facility submitted an acceptable Removal Plan. On 1/27/21, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating all facility staff on [REDACTED] Risk Evaluation and auditing all residents' charts who had a diagnosis of [REDACTED] Disorder and who were on [REDACTED] medications; thirty residents were identified. Twelve of those residents were referred for evaluation and	F 000		

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F 000	Continued From page 2 psychotherapy services.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ141650, NJ142287 Based on interviews, medical record (MR) review, and review of other pertinent facility documentation on 1/15/21, 1/20/21, and 1/27/21, it was determined that the facility failed to provide services necessary to prevent physical harm for a resident (Resident #2) with a known history and diagnosis of [redacted] [redacted]. On 12/5/20, Resident #2 became tearful and upset after a telephone conversation with the resident's family member. Resident #2 expressed to the Licensed Practical Nurse (LPN #1) at approximately 11:40 p.m. that the resident's family member did not want him/her to go home, and th [redacted] [redacted] LPN #1 stayed with Resident #2 for approximately 5 minutes and then	F 600	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors□ findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. F600: SCOPE and SEVERITY = J CFR(s): 483.12(a)(1)483.12 Freedom from Abuse, Neglect, and Exploitation.	2/22/21

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F 600	Continued From page 3 left Resident #2 alone. At 11:57 p.m., approximately 17 minutes later, while walking past the resident's room, the Certified Nursing Assistant (CNA #1) found Resident #2 hanging off the bed with the floor and yelled for the nurse. LPN #1 responded and found Resident #2 had the times. The nurse removed the Resident 2's and placed the resident backdown into bed on the back. Resident #2 had . The facility neglected to implement the care plan interventions to monitor for target behaviors, which included to monitor, document, and report to the Medical Doctor (MD) any ongoing signs and symptoms of or comments. There was no documented evidence in the care plan that interventions were evaluated for their effectiveness. In addition, the facility neglected to provide services for the resident, and the facility failed to provide all staff educational training for behavioral mood changes and /prevention for a resident dealing with . The facility also failed to follow its policies and procedures titled - Clinical Protocol," Threats," "Physician's Notification for Consultation," and "Behavior Assessment, Intervention and Monitoring." This placed Resident #2 and all other residents experiencing symptoms of and the will not at risk for an Immediate Jeopardy (IJ) situation. This IJ was identified on 1/20/21 at 3:35 p.m. and reported to the Administrator and the Director of Nursing (DON). The Administrator and DON were presented with the IJ template that included information about	F 600	Resident #2 no longer resides in the facility as CORRECTIVE ACTIONS: ¿ LPN #1 (Nurse who was assigned to Resident #2 at that time stated my was provided with 1:1 Counseling re: providing services necessary to prevent physical harm for a resident with a known history and diagnosis of Emphasis was made on the need to implement care plan interventions to monitor for target behaviors, document and report to the Medical Doctor (MD) any ongoing signs and symptoms of) and evaluate the effectiveness of the interventions. ¿ 19 staff members were re-in-serviced and all remaining staff were in-serviced on the facility□s Policies and Procedures re: - Clinical Protocol," " Threats," "Physician's Notification for Consultation," and "Behavior Assessment, Intervention and Monitoring." Emphasis was made on the identification of behavioral mood changes and prevention for a resident dealing with IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ Residents with diagnosis of and all residents that	

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F 600	Continued From page 4 the issue. The IJ was lifted on 1/20/21 at 5:09 p.m. when the facility submitted an acceptable Removal Plan. On 1/27/21, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating all facility staff on [redacted] Evaluation and auditing all residents' charts who had a diagnosis of [redacted] and who were on [redacted] medications; thirty residents were identified. Twelve of those residents were referred for evaluation and [redacted] services. This deficient practice was evidenced by the following: According to the "Admission Record (AR)," Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. Also, in the MDS under Section D D0200 Resident Mood Interview (PHQ-9), a depression screen revealed Resident #2 showed [redacted] The [redacted] screen indicated that Resident #2 had a total of thirteen episodes of [redacted]," and had trouble falling asleep or sleeping too much, and feeling tired or having little energy, present at least once for several days.	F 600	voice the need to harm themselves have the potential to be affected by the same deficient practice. To identify these residents, the facility performed the following: " Facility generated a list of all residents who have a Diagnosis of [redacted] from the Facility□s Clinical Software (Point Click Care). " A roster of all residents on [redacted] was generated from EMAR in Point Click Care. ¿ Upon completion of the above, 30 residents were identified with Diagnosis of [redacted] Disorder and who were on [redacted] medications. ¿ A list of the above residents was created by the Director of Nursing. This list will be updated by the Director of Nursing or Designee when changes occur, e.g. Add Residents who are admitted with Diagnosis of [redacted] Disorder, Remove names of discharged residents, etc. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ The medical records of the residents who were noted with a diagnosis of [redacted] disorder and were on [redacted] medications were audited by the IDCP Team. Care plans were reviewed and updated as appropriate. MD orders were obtained for [redacted] Evaluations and Services for appropriate residents. The referrals were made to [redacted] Services and all these identified residents were seen by [redacted] as ordered.	

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F 600

Continued From page 5

Review of the Facility's Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by the healthcare facilities to report incidents dated [redacted], with an event date of [redacted] and a "time of event" of 11:57 p.m., revealed the following:

According to the "Timeline of Events (TLE)" indicated on [redacted] at 11:40 p.m., LPN #1 went into Resident #2's room to flush the Resident's [redacted] The TLE indicated Resident #2 appeared to be upset after a recent phone call with a family member about discharge, and LPN #1 offered Resident #2 reassurance. The TLE also revealed that at 11:57 p.m., the Certified Nursing Assistant (CNA #1) entered Resident #2's room while doing rounds and found Resident #2 on [redacted] next to the bed, and called LPN #1 to the room.

The TLE also indicated that LPN #1 found [redacted] around Resident #2's [redacted]; the LPN removed the call bell from around Resident 2's [redacted]. The resident was assessed was not responding and [redacted] was applied, and the LPN did not resuscitate the resident due to the DNR (Do Not Resuscitate) status.

Further review of the TLE noted that the Director of Nursing (DON), the Administrator, and the local police department were notified. Resident #2 was pronounced dead by the Medical Examiner between 2:10 a.m. and 2:13 a.m.

Review of the "Individual Statement Form (ISF) dated [redacted], written by CNA #1 showed "I saw the resident half out of bed, I called for the nurse to help me when we position (him/her) back on the bed, we found the [redacted] [his/her] [redacted]

F 600

¿ All staff were re-in-serviced on the facility□s Policies and Procedures re: "[redacted] - Clinical Protocol," [redacted] Threats," "Physician's Notification for Consultation," and "Behavior Assessment, Intervention and Monitoring." Emphasis was made on the identification of behavioral and mood changes and management of residents with [redacted] Disorder who express [redacted] and what staff must immediately do to promote resident safety.

¿ All nurses were educated on Facility□s updated Policy on [redacted] Risk Screening and Prevention. This includes the following:

" Physician Notification of a significant change in mood or resident verbalizations of [redacted] thoughts such as I do not think I want to live like this or a desire to self-inflict physical harm

" Referral for [redacted] Services

" Completion of the [redacted] SCREENER TOOL for residents who express suicidal ideations or thoughts. The [redacted] SCREENER TOOL is the [redacted] Risk Screening Tool recommended by the Administration on Aging and SAMHSA (Substance Abuse & Mental Health Services Administration) for health and human service professionals to use in assessing [redacted] risk and take appropriate actions to keep older adults safe. This Guidance is detailed in an Issue Brief entitled Preventing [redacted] in Older Adults.

" 1:1 Monitoring and Support as appropriate. 1:1 monitoring, and emotional support will be provided by a designated staff member that will remain

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F 600

Continued From page 6

A review of the ISF dated [redacted], written by LPN #1, revealed that on [redacted] at 11:40 p.m., LPN #1 went into Resident #2's room to unhook the resident's [redacted] the resident's [redacted]. The ISF further revealed that Resident #2 appeared to be upset about a conversation on the phone with a relative. At 11:57 p.m., the CNA called the nurse and mentioned the resident looked like he/she was getting out of bed. LPN #1 went into Resident #2's room and checked on the resident. The ISF also indicated both of Resident #2's [redacted] were on the floor, with the [redacted] of the resident's [redacted] leaning against the bed. When the nurse slightly repositioned the resident, the nurse noticed that the [redacted] was around the resident's [redacted] The nurse then removed the [redacted] around the resident's [redacted] and was helped by a male CNA to place the resident back in bed on his/her back.

Further review of the ISF also showed that Resident #2 was assessed for [redacted]. The ISF also showed the [redacted] was administered at [redacted]. However, Resident #2 had no [redacted] and or [redacted] present. According to the ISF, there were no attempts to resuscitate Resident #2 due to a Do Not Resuscitate/ Do Not Intubate status.

A review of the Electronic Medical Record (EMR) revealed the following:

Resident #2's Care Plan (CP) dated [redacted] showed the following:

Under: Focus: I use [redacted] medication (s) r/t (related to) my diagnosis of Target

F 600

with the resident on each shift. Staff will inform the resident of the reason behind their actions and communicate their concern for the resident. A staff member will remain with the resident and will not leave the resident alone until a physician has determined that a risk of [redacted] does not appear to be present or until the resident is transferred to the hospital for further evaluation and management.

" Facility procured the services of an additional [redacted] Services Company to ensure that residents with MD Orders for [redacted] will receive services as ordered. All staff were educated on the availability of the 2 Providers of [redacted] Services and [redacted] Services

MONITORING OF CORRECTIVE ACTIONS

¿ Regional Educator, DON or designee will complete a [redacted] Risk Assessment, utilizing the [redacted] SCREENER TOOL on 3 Residents with diagnosis of [redacted] on a weekly basis x 6 months.

¿ Any issued identified in the audits will be addressed immediately.

¿ Findings will be reported to the Administrator on a weekly basis and to the QAPI Committee on a monthly basis.

COMPLETION DATE: February 22, 2021

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F 600	Continued From page 7 Behaviors: 1). self-isolation 2). sad mood 3). excessive sleeping. Under: Goal showed "I will be free from discomfort or adverse reactions r/t [redacted] therapy through the review date." Under "Interventions" included: "Monitor/document/report to MD (medical doctor) prn (whenever necessary) ongoing s/sx (signs or symptoms) of [redacted] unaltered by [redacted] meds: [redacted] neg. (negative) mood/comments, slow movement, agitation, disrupted sleep, fatigue, ... changes in weight, appetite, ... attention-seeking ... anxiety, constant reassurance." A review of the "Order Summary Report" revealed the following: [redacted]) Tablet [redacted] mg (milligram). Give 1 tablet by mouth (PO)at bedtime related to [redacted] A review of the December 2020 "Medication Administration Record (MAR)" showed Resident #2 refused all medications to be given by mouth on [redacted], on the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts. A review of the Progress Notes(PN) dated [redacted] at 12:15 p.m., written by LPN #2, revealed that Resident #2 refused medication on the 7:00 a.m. to 3:00 p.m. shift. There was no documentation in Resident #2's Medical Record (MR) to support that the LPN notified the MD that the resident refused his/her medications. A review of the PN dated [redacted] at 11:00 p.m.,	F 600		

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F 600	Continued From page 8	F 600		

written by LPN #1, showed Resident #2 refused all by mouth medication on the 3:00 p.m. to 11:00 p.m. shift. There was no documentation in Resident #2's MR that the LPN notified the MD that the resident refused medications, including the [redacted]

During an interview on 1/15/21 at 12:12 p.m., with the Administrator and the DON, the DON stated that when a resident refuses medications, the doctor needs to be notified. The Administrator stated that it should be documented in the resident's PN if the doctor was notified.

During a telephone interview on 1/20/21 at 10:12 a.m., LPN #1 stated Resident #2 "refusing meds [medications] was a change." LPN #1 stated that he was made aware by the 7:00 a.m. to 3:00 p.m. shift nurse that Resident #2 refused his/her medications. LPN #1 indicated, Resident #2 also refused his/her medications on the 3:00 p.m. to 11:00 p.m. shift; however, LPN#1 stated that he did not notify the MD.

The PN also revealed that on [redacted] at 11:57 p.m., LPN #1 and CNA #1 went to check on Resident #2; the resident had both [redacted] on the floor with the [redacted] of the resident's [redacted] leaning against the bed. "When the nurse slightly repositioned the resident, the nurse noticed that the [redacted] the resident's [redacted] The PN also revealed that the LPN removed the cord from around Resident #2's [redacted]. CNA #2 assisted the LPN to place Resident #2 back into bed in the supine position. Resident #2 was checked by LPN #1 and LPN #2 for [redacted] [redacted], and any response." The LPN's also performed [redacted], but Resident #2 had no reactions or response.

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F 600	Continued From page 9 Further review of the PN revealed, ' [redacted] was present, even with [redacted] During an interview on 1/15/21 at 10:20 a.m., the Unit Manager (UM) stated if a resident reported that the resident wanted [redacted] he/she wanted [redacted]; the first thing she would do is make sure the resident was safe. The UM explained she would question the resident to determine if the resident has a plan. The UM further explained she would then make sure the resident was safe by putting the resident's bed into the lowest position so the resident will not push himself/herself off the bed. The UM also stated that she would remove any [redacted] in the room and any [redacted] such as the [redacted] and [redacted]. Also, the UM stated she would notify the DON and the MD. During an interview on 1/15/21 at 11:25 a.m., the Social Worker (SW) indicated that Resident #2 was admitted for [redacted] services and to be transitioned to long-term care (LTC). The SW stated Resident #2 family member said they could not take the resident back home. The SW further explained that at times Resident #2 seemed "really upset" having to stay in a LTC facility. During an interview on 1/15/21 at 12:52 p.m., CNA #1 stated she was told previously by the nurse to "show some extra care" towards Resident #2, the resident was upset because the family member did not want him/her back home. CNA #1 stated she was not assigned to Resident #2 on [redacted] when the resident [redacted]. According to CNA #1, she heard	F 600		

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F 600	Continued From page 10 Resident #2 yelling during the beginning of the shift, which was unusual behavior for the resident. CNA #1 explained later in the shift while walking down the hallway she observed Resident #2 halfway out of bed while walking past Resident #2's room. The CNA said, "I thought it was a behavior thing," and called LPN #1. CNA #1 explained LPN #1 and another CNA (CNA #2) responded to Resident #2's room; both of the resident's [redacted] were on the floor, and the resident had the [redacted]. CNA #1 also stated Resident #2 was [redacted] in color. During a telephone interview on 1/15/21 at 1:50 p.m., CNA #2, who was from an agency company, stated he was assigned to Resident #2 on [redacted] when the resident [redacted] but was not aware that the resident was [redacted] CNA #2 explained he became aware of the resident's behavior after the incident occurred. CNA #2 indicated the facility did not educate him on mood changes, behaviors, and [redacted] / prevention prior to the incident. On 1/15/21 at 1:36 p.m., the DON provided the Surveyors with 19 certificates of completion for a training on [redacted] Risk, two of which were completed by LPN's and two by CNA's prior to Resident #2 [redacted] on [redacted] However, LPN #1 was not included in this training. The DON stated this training was not in response to Resident #2 [redacted]. The DON also stated there was no mandatory staff education provided for staff related to [redacted] risk or prevention that was held prior to Resident #2 [redacted]. The DON stated LPN #1 was not provided with the training on [redacted] risk after Resident #2 [redacted].	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 11 During the telephone interview on 1/20/21 at 10:12 a.m., LPN #1 stated he was not educated on [redacted] prevention. LPN #1 explained he went into Resident #2's room at 11:40 p.m. to [redacted] Resident #2 had just gotten off of the phone with the resident's family member and told the LPN, "my [wife/husband] doesn't want me back home. I don't want to live anymore." The LPN stated Resident #2 "was [redacted] and [redacted] The LPN indicated Resident #2 "was upset, and it was a drastic change" for the resident. LPN #1 stated it was almost like Resident #2 was "throwing a fit." LPN #1 continued to explain he has never seen Resident #2 in this manner and stayed with the resident to calm [him/her] down, and he told Resident #2 he would call the resident's family member to "get to the bottom of it." LPN #1 stated he did not know what happened during the conversation that the resident had on the phone and that something must have pushed him/her 'over the edge". The LPN stated Resident #2 "calmed down within five minutes, took a deep breath and closed his/her eyes." LPN #1 then left the room and told the incoming nurse, "we might have to call (Resident #2's) family just to give (the resident) peace of mind to ensure him/her everything will be okay." LPN #1 further explained he did not know what Resident #2 meant when the resident said [redacted] and sometimes residents are quick to say certain things and do not mean it. When asked by the Surveyors why he did not notify Resident #2's physician after the resident stated he/she was [redacted] and was upset and crying like, the LPN stated, "We should have called the doctor" and should not have left Resident #2 alone in his/her room. According to LPN #1, CNA #1 called him to Resident #2's room, he found	F 600		

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	315333	A. BUILDING ______ B. WING ______	C 01/27/2021

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F 600	Continued From page 12 Resident #2 with the [redacted] of the resident's body on the bed, and the resident's [redacted] turned towards the wall. The [redacted] Resident #2's [redacted] times. LPN #1 stated, "the protocol is to call the doctor, which we didn't do." The LPN also stated, "I was not supposed to leave a resident alone who said [redacted] During an interview on 1/20/21 at 12:19 p.m., in the presence of the Administrator, the DON stated if someone believed [redacted] you would have to investigate further the person's feelings at the time and ask what do you mean by that?" A review of the Consultation report dated [redacted] by the [redacted] group, completed by the Nurse Practitioner (NP), showed the resident had [redacted] features. The physical exam showed the resident was [redacted]" Also, Resident #2 had increase [redacted] related to separation from the resident's family member. Further review of the Consultant Report revealed a "Mood Scale" total evaluation score of [redacted], which indicated that the resident might be [redacted]. The Consultation evaluation also revealed the following: [redacted] Further review of the consultation report specified	F 600		

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F 600	Continued From page 13	F 600		

recommendations for Resident #2 as follows:

"(1) Continue [redacted] mg at HS (hour of sleep).
(2) Provide [redacted]
(3) Arrange more frequent video zoom visits with [family member]."

During an interview on 1/20/21 at 11:15 a.m. the NP who evaluated the resident stated Resident #2's [redacted] scale was elevated due to (the resident) not seeing (his/her) family." The NP stated Resident #2 would have benefited from [redacted] because the resident had MCI and was [redacted] The NP indicated if a resident made the statement "[redacted] [redacted]," this should be investigated further by asking the resident questions such as "[redacted] [redacted] The NP explained that regardless of the resident's statements and symptoms, the facility's protocol should still be followed.

A review of Resident #2's EMR and documents provided by the facility for review revealed no documented evidence that the resident was ordered [redacted], nor was there a reason why this therapy was not provided to the resident.

During an interview on 1/15/21 at 11:25 a.m., the Social Worker (SW) stated he referred Resident #2 for [redacted] services but the resident was not seen. However, the SW was unable to provide proof that Resident #2 was referred for services.

During an interview on 1/20/21 at 12:19 p.m., in the DON's presence, the Administrator stated the [redacted] who comes to the facility to do the [redacted] was sick and could not make the appointment.

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F 600	Continued From page 14 During an interview on 1/27/21 at 12:16 p.m. in the Regional Nurse Consultant (RNC) and the DON's presence, the Administrator stated she was not sure if the [redacted] group was aware of the referral. The Administrator further explained that she requested the list of residents recommended for [redacted] from the company but did not receive the list. Nevertheless, the Administrator was unable to provide proof that Resident #2 was referred for [redacted] services. During an interview on 1/27/21 at 12:16 p.m., in the Administrator and the DON's presence, the RNC stated the [redacted] screening is done upon admission; therefore, the SW should have been keeping track of Resident #2. Review of the facility policy titled [redacted] Clinical Protocol" updated 10/19, revealed the following: Under "Assessment and Recognition" included "2 .... The nurse shall assess and document/ report the following: e. If [redacted] is present, follow facility policy/ protocol for [redacted] threats; 3. Using appropriate screening tools, the staff will screen residents for [redacted] on admission and subsequently, if suggested by changes in mood, function, or behavior. 4. Staff will observe residents for possible signs and symptoms of [redacted] especially individuals who had a history of [redacted] other [redacted] disorder (s), a screening test result that indicates possible [redacted], or those with significant risk factors. A. Signs and symptoms may include, among others, [redacted] mood most of the day, almost every day; ... thoughts of death or [redacted]; [redacted]; ... changes in sleep pattern or appetite; or	F 600		

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F 600	Continued From page 15 avoidance of social interactions. b. Examples of risk factors for [redacted] include alcohol or substance abuse, current use of a medication associated with a high risk of [redacted]... new admission or change in environment, and new stressful losses including loss of autonomy, privacy, functional status, a body part or a family member or friend." Under "Treatment/Management" included "1. The staff will provide pertinent non-pharmacological interventions for the individual with [redacted]; for example, address related environmental, spiritual, and family issues." A review of the facility policy titled "[redacted] Threats," updated 10/20, revealed the following: Under "Policy Statement" included "Resident suicide threats shall be taken seriously and addressed appropriately." Under "Policy Interpretation and Implementation" 3. A staff member should remain with the resident until the Nurse Supervisor/Charge Nurse arrives to evaluate the resident. 4). After assessing the resident in more detail, the Nurse Supervisor / Charge Nurse shall notify the Resident's Attending Physician and responsible party and shall seek further direction from the Physician. 5). All nursing personnel and other staff involved in caring for the resident shall be informed of the [redacted] threat and instructed to report changes in the Resident behavior immediately." Review of the facility's policy titled "Physician Notification for Consultations" adopted 11/18 under "Policy Statement:" revealed, "It is the policy of ... to notify the Physician for a resident having consultation of supportive services. A consultation is defined as supportive service provided with an expert or professional, such as a specialist or medical doctor, to seek advice or	F 600		

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F 600	Continued From page 16 recommendations in a patient's physical, mental, and psychosocial status." Review of the facility policy titled "Behavior Assessment, Intervention and Monitoring" updated 10/19, revealed the following: Under "Management" included 1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately, if necessary, to protect the resident and others from harm. On 1/27/21, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating all facility staff on [redacted] Risk Evaluation and auditing all residents' charts who had a diagnosis of [redacted] Disorder and who were on [redacted] medications; thirty residents were identified. Twelve of those residents were referred for evaluation and [redacted] services. N.J.A.C:8:39-11.2 (b) N.J.A.C:8:39-4.1(a)(5)	F 600		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		2/22/21

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F 656	Continued From page 17 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the 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#: NJ141650, NJ142287 Based on interviews, medical record reviews and review of pertinent facility documentation on	F 656	This Plan of Correction is submitted as required under Federal and State regulation and statutes applicable to long term care providers. This Plan of Correction does not constitute an	

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F 656

Continued From page 18

1/15/21, 1/20/21 and 1/27/21, it was determined that the facility failed to revise and implement care plan interventions for a resident (Resident #2) with a [redacted] disorder who demonstrated mood and behavioral changes in the presence of staff and then [redacted]. This deficient practice was evident in 1 of 3 care plans reviewed as evidenced by the following:

According to the "Admission Record" Resident #2 was admitted to the facility on [redacted] with diagnoses which included, but were not limited to, [redacted]

According to the admission Minimum Data Set (MDS), dated [redacted], Resident #2 had a Brief Interview for Mental Status score of [redacted], which indicated the resident was cognitively intact. The resident's mood interview, [redacted] screening), indicated that the resident had 12-14 days (nearly everyday) of [redacted]

Review of Resident #2's Care Plan revealed a "Focus" initiated on [redacted], for the resident's use of antidepressant medication (s) resulted to a diagnosis of: (blank) and "Target Behaviors: 1) self isolation 2) sad mood 3) excessive sleeping."

The Care Plan further revealed a "Goal" initiated [redacted] with a target date of [redacted], which revealed the resident "will be free from discomfort or adverse reactions related to [redacted] therapy through the review date."

The Interventions initiated [redacted] included for

F 656

admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.

F656: SCOPE and SEVERITY = G
CFR(s): 483.21(b)(1) Develop/Implement Comprehensive Care Plan

Resident #2 no longer resides in the facility as [redacted]

CORRECTIVE ACTIONS:

¿ The IDCP Team was re-in-serviced re: the importance and significance of revising and implementing care plan interventions for residents with Diagnosis of [redacted] Disorder, specifically those who demonstrate mood and behavioral changes.

¿ Emphasis was made on the need to monitor for target behaviors, document and report to the Medical Doctor (MD) any on-going signs and symptoms of [redacted]) and evaluate the effectiveness of the interventions.

IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE

¿ Residents with diagnosis of [redacted] Disorder and all residents that

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F 656	Continued From page 19 nursing to "monitor/document/report to medical doctor as needed ongoing signs and symptoms of [redacted] meds: [redacted], slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears attention seeking concern with body functions, anxiety, constant reassurance". Another Intervention initiated [redacted] revealed for certified nurse aide and nursing to "report to the nurse signs and symptoms the following: confusion, mood change, change in normal behavior, hallucinations/delusions, social isolation, suicidal ideations, withdrawal, decline in ability to help with/do activities of daily living, continence, cognitive function, constipation, fecal impaction, no voiding, shuffle gait, rigid muscles, difficulty ambulating, balance problems, insomnia, appetite loss, weight loss, muscle cramps, nausea/vomiting." A Care Conference note dated [redacted] revealed the attendance at the meeting included nursing, therapy, activities, dietary, social services and Resident #2's family member by telephone. The [redacted]) section revealed Resident #2 took [redacted] medication [redacted] milligrams related to [redacted] disorder and was referred to a gerontology group and [redacted] for added support, and under Discharge Planning the resident was to transition to long term care. On 1/15/21 at 11:25 AM the surveyors	F 656	voice the need to harm themselves have the potential to be affected by the same deficient practice. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ The Care plans of the residents who have a diagnosis of [redacted] disorder and are on [redacted] medications were reviewed by the IDCP Team. The IDCP Team evaluated the effectiveness of interventions and care plans were updated accordingly. ¿ MD orders were obtained for [redacted] Evaluations and Services for appropriate residents. The referrals were made to [redacted] Services and all these identified residents were seen by [redacted] as ordered. MONITORING OF CORRECTIVE ACTIONS ¿ Unit Manager or Designee will audit the charts of 5 Residents with diagnosis of [redacted] Disorder on a weekly basis x 6 months. Audit will focus on the following. o A care plan is established to monitor for target behaviors, e.g. any signs and symptoms o [redacted] or comments) o Interventions are in place to address any mood changes or behaviors; including but not limited to: Physician Notification; Referral for [redacted] Services; Completion of [redacted] Risk Assessment; etc.	

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F 656	Continued From page 20 interviewed the facility social worker (SW) who stated the gerontology group completed resident [REDACTED] medication management and the other group was the psychology group that met with the residents weekly. He stated he completed the [REDACTED] which is the depression screen part of the MDS which referred to the resident's mood for the past two weeks and he stated he authored the Care Conference note. He stated it was discussed at the care conference meeting that the resident was not returning home. He further stated Resident #2's family member was "adamant" that Resident #2 could not return home. The SW further stated that Resident #2 was agitated at times because the family member was unable to care for him/her. The SW stated he did not participate in the development of the resident's care plan and it was not part the interdisciplinary team meeting. On 1/20/21 at 9:44 AM, the surveyors interviewed the Material Data Set (MDS) Coordinator (MDS). She stated she was responsible for completing Resident #2's care plan and developed care plans for areas that triggered on the MDS. The MDS Coordinator stated she was not present at the resident's care plan meeting that was held on [REDACTED] In the presence of two surveyors, the MDS Coordinator reviewed Resident #2's Care Plan with the Focus of [REDACTED] Medication(s) and confirmed she completed the care plan. She stated the care plan was a computer template based on the triggered areas on Resident #2's MDS and [REDACTED] was included in the care plan template. She stated the purpose of the resident care plan was to guide anyone who provided care for a resident and the care plan would let the caregiver know what the resident's	F 656	o Documentation that reflects evaluation of the effectiveness of care plan. o Care plan is updated accordingly. ¿ Any issued identified in the audits will be rectified immediately. ¿ Findings will be reported to the DON and the Administrator on a weekly basis x 6 months and to the QAPI Committee on a monthly basis x 6 months. COMPLETION DATE: February 22, 2021	

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F 656	Continued From page 21	F 656		

care needs were. The surveyors inquired as per the care plan, what should have been done when Resident #2 expressed that [redacted] She stated when Resident #2 stated he/she [redacted], that that would have been considered a negative mood or comment and it "should not" have been ignored and it should have been reported to the physician.

A review of the Progress Note dated [redacted] at 23:40 (11:40 PM) written by Licensed Practical Nurse (LPN #1), revealed Resident #2 appeared to be upset about a conversation with a family member. The PN also revealed Resident #2 verbalized to LPN #1 [redacted] ". Further review of the PN showed LPN #1 offered one on one support for the resident and offered to call the family to talk to them to find out what exactly happened.

During a telephone interview on 1/20/21 at 10:15 AM, LPN #1 stated during that encounter with Resident #2 that he could clearly see that Resident #2 was upset about something to do with his/her family. He stated that during the shift on [redacted] at 22.22 (10:22 PM), Resident #2 refused to take his/her medications and LPN #1 tried to encourage the resident to take them. LPN #1 stated it was almost like Resident #2 was "throwing a fit." LPN #1 stated this behavior was not exhibited by Resident #2 prior to the phone call that the resident received from the family member. LPN #1 stated he did not know what happened during the conversation that the resident had on the phone and that something must have pushed him/her 'over the edge". He stated that after the phone call Resident #2 was really upset and was crying, and that he had never seen the resident like that. He stated it

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F 656		F 656		

Continued From page 22
almost seemed "out of the blue" for Resident #2 to act like that and that the behavior was a "definitely a change in mood" for the resident.

LPN #1 stated he told Resident #2 that he would call the family to try to see what happened and it looked like the resident had calmed down. He stated he did not call the resident's physician and instead endorsed to the next shift that the next shift may need to reach out the family (not the physician) because the resident was really upset and that LPN #1 "had never seen the resident cry like that".

The surveyors inquired to LPN #1 if he should have contacted the resident's physician after resident #2 stated he/she [redacted] [redacted] like he had never seen before. LPN #1 stated that he should have called the physician and Resident #2 should not have been left alone.

The Behavioral Assessment, Interventions and Monitoring policy, updated 10/2019 revealed under Management, the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. "Safety strategies will be implemented immediately if necessary to protect the resident from harm."

The Care Plans, Comprehensive Person-Centered policy, updated 10/2020 revealed a Policy Statement "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implemented for each resident."

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	315333	A. BUILDING ______ B. WING ______	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST TOMS RIVER, NJ 08757

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F 656	Continued From page 23 NJAC 8:39- 27.1(a)	F 656		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: C#: NJ141650, NJ142287	F 741	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long	2/22/21

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F 741	Continued From page 24 Based on interviews and review of pertinent facility documentation on 1/15/21, 1/20/21 and 1/27/21, it was determined that the facility failed to educate staff on [redacted] risk and prevention and ensure staff had the appropriate competencies to provide care for residents who exhibited a change in mood and verbalized [redacted]. This deficient practice occurred for 1 of 3 sampled residents (Resident #2) reviewed for a change in mood and expressed to staff wishes of [redacted] and then [redacted] This deficient practice was evidenced by the following: According the the "Admission Record" Resident #2 was admitted to the facility on [redacted] with diagnoses which included, but were not limited to, [redacted] According to the admission Minimum Data Set, dated [redacted], Resident #2 had a Brief Interview for Mental Status score of [redacted], which indicated the resident was cognitively intact. The resident mood [redacted]) indicated that the resident had thirteen episodes of [redacted] [redacted]". Review of a Progress Note (PN) completed by the Licensed Practical Nurse (LPN #1) dated [redacted] at 23:40 (11:40 PM) revealed; the resident appeared to be upset about a conversation with a family member. Resident verbalized [redacted] Nurse offered one on one support for the resident	F 741	term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. F741: SCOPE and SEVERITY = E CFR(s): 483.40(a)(1)(2) Sufficient/Competent Staff-Behavioral Health Needs Resident #2 no longer resides in the facility as [redacted] CORRECTIVE ACTIONS: ¿ 19 staff were re-educated and all remaining staff were in-serviced on Facility s Policy on [redacted] Risk and Prevention. Emphasis was made on the identification of behavioral mood changes, [redacted] Prevention for residents who exhibit a change in mood and verbalized thoughts of no longer wanting to live. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ Residents with diagnosis of [redacted] [redacted] Disorder and all residents that voice the need to harm themselves have the potential to be affected by the same deficient practice. To identify these residents, the facility performed the following:	

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F 741	Continued From page 25 and offered to call the family to talk to them to find out what exactly happened. Review of a PN completed by LPN #1 dated [REDACTED] at 23:57 (11:57 PM) revealed the nurse went to check on Resident #2 with a Certified Nurse Aide. Both of Resident #2's [REDACTED] were on the floor and the [REDACTED] of the resident's body was leaning against the bed. When the nurse slightly re-positioned the resident, the nurse noticed the [REDACTED] the resident's [REDACTED] The nurse removed the [REDACTED] [REDACTED] the resident's [REDACTED] and was then helped by a male CNA (CNA #2) to place Resident #2 back into the resident's bed in a supine position. [REDACTED] was present and there was no attempt to resuscitate the resident due to Resident #2's advanced directives. Review of an Individual Statement Form, dated [REDACTED] at 12:00 AM and completed by CNA #1 revealed that "I saw the resident earlier when I came on the floor. [He/She] was calling out at various times. When I was walking down the 20 hall I saw the resident half out of the bed. I called for the nurse to help me. When we put [him/her] back on the bed; we found the [REDACTED] [REDACTED] [his/her] [REDACTED]. On 1/15/21 at 12:52 PM two surveyors conducted a telephone interview with CNA #1. CNA #1 stated she worked on [REDACTED] and the Resident was not on her assignment that day. She stated she had provided care for Resident #2 a few times and she knew that Resident #2 was upset because the resident knew he/she was not returning home. She stated that she was informed by a nurse a few days prior to the resident [REDACTED], that the resident	F 741	SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ 19 staff were re-in-serviced and all remaining staff were in-serviced on the facility□s Policies and Procedures re: [REDACTED]- Clinical Protocol," "[REDACTED] Threats," "Physician's Notification for Consultation," and "Behavior Assessment, Intervention and Monitoring." Emphasis was made on the identification of behavioral and mood changes and management of residents with Major [REDACTED] Disorder who express [REDACTED] [REDACTED] and what staff must immediately do to promote resident safety. ¿ All nurses were educated on Facility□s updated Policy on [REDACTED] Risk Screening and Prevention. This includes the following: o Physician Notification of a significant change in mood or resident verbalizations of [REDACTED] thoughts such as I do not think I want to live like this or a desire to self-inflict physical harm o Referral for [REDACTED] Services o Completion of the [REDACTED] SCREENER TOOL for residents who express suicidal ideations or thoughts. The [REDACTED] SCREENER TOOL is the [REDACTED] Risk Screening Tool recommended by the Administration on Aging and SAMHSA (Substance Abuse & Mental Health Services Administration) for health and human service professionals to use in assessing [REDACTED] risk and take appropriate actions to keep older adults safe. This Guidance is detailed in an Issue Brief entitled Preventing [REDACTED] in Older Adults.	

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F 741	Continued From page 26 needed to be shown extra care because the resident was aware that his/her family did not want him/her to come back home. She stated that while at the nursing station around 11:00 PM on [redacted] she overheard Resident #2 calling out from his/her room. She stated that Resident #2 was "not one of the people that usually called out" and she could not hear what he/she was saying. She stated she did not respond to Resident #2 calling out and she then proceeded to assist another CNA, and in doing so walked passed Resident #2's room. She stated when she passed by Resident #2's room she observed the resident was half-way out of the bed. She stated at that time she thought it was a "behavior thing". CNA #1 stated she did not enter Resident #2's room at that time and went to get LPN #1 to enter the room with her to assist with Resident #2. She stated at that time she observed that Resident #2 was [redacted] and was on the floor with the [redacted]/her [redacted]. The surveyors inquired to CNA #1 if she had received training on [redacted] risk or prevention and she stated she could not recall that she received any training related to [redacted] prior to the incident. On 1/15/21 at 1:50 PM two surveyors conducted a telephone interview with CNA #2 who stated he worked at the facility four to five days per week. He stated he provided care for Resident #2 on [redacted]. The surveyors inquired to CNA #2 if he was educated by the facility on [redacted] risk or [redacted] prevention and he stated no. On 1/20/21 at 9:44 AM, the surveyors conducted a telephone interview with LPN #1. The surveyors inquired if LPN #1 was provided with education from the facility on [redacted] risk or prevention. LPN #1 stated he did not receive education on [redacted] risk or prevention.	F 741	o 1:1 Monitoring and Support as appropriate. 1:1 monitoring, and emotional support will be provided by a designated staff member that will remain with the resident on each shift. Staff will inform the resident of the reason behind their actions and communicate their concern for the resident. A staff member will remain with the resident and will not leave the resident alone until a physician has determined that a risk of [redacted] does not appear to be present or until the resident is transferred to the hospital for further evaluation and management. MONITORING OF CORRECTIVE ACTIONS ¿ Department Heads will interview 5 Staff Members per week x 3 months to assess staff□s knowledge of Facility□s Policy on [redacted] Risk and Prevention and to ensure that they have the appropriate competencies to provide care for residents who exhibit a change in mood and who verbalized [redacted]. A questionnaire will be utilized for the interviews. ¿ Findings will be reported to the Administrator on a weekly basis and to the QAPI Committee on a monthly basis. COMPLETION DATE: February 22, 2021	

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F 741	Continued From page 27 The facility provided time punch log for LPN #1 for the period of [redacted] through [redacted] was reviewed. The time punch log revealed LPN #1 worked at the facility for twenty-three days after Resident #2 [redacted] and without receiving education on [redacted] risk or prevention. During interviews held on [redacted] and [redacted] between the Director of Nursing (DON), administrator, and two surveyors, the surveyors inquired about any staff education that was provided on [redacted] risk or prevention. The DON stated there was no mandatory staff education provided for staff related to [redacted] risk or prevention that was held prior to Resident #2 [redacted] On 1/15/21 at 1:36 p.m., the DON provided the Surveyors with 19 certificates of completion for a training on [redacted] Risk, two of which were completed by LPN's and two by CNA's prior to Resident #2 [redacted] on [redacted]. However, LPN #1 was not included in this training. The DON stated this training was not in response to Resident #2 [redacted]. The DON also stated there was no mandatory staff education provided for staff related to [redacted] risk or prevention that was held prior to Resident #2 [redacted]. The DON stated LPN #1 was not provided with the training on [redacted] risk after Resident #2 [redacted]. The DON provided information on the purpose of the [redacted] risk training. The purpose of the training revealed that the educational activity was to enable the learner to understand the scope of [redacted] among older adults, recognize individuals at risk, and identify resources for assistance. Further review of the 19 certificates of completion	F 741		

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F 741	Continued From page 28 for the [redacted] Risk revealed the training was completed by the nursing staff as of 1/15/21. The certificates did not include [redacted] risk training was completed by either LPN #1, CNA #1 or CNA #2 and was completed for 19 out of 41 nursing staff per review of the facility provided nursing staff roster. NJAC 8:39-27.1(a)	F 741		