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F 000	INITIAL COMMENTS Complaint #: 135692, 135693, 138133, 132852, 138213, 137702, 135993, 137018, 138064 Survey Date: 08/18/20 Census: 98 Sample Size: 8 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT VISIT.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ 00137702 Based on observation, interview, and record review, it was determined that the facility failed to a) properly assess and monitor the bowel function of a resident receiving stool softeners and laxatives daily in order to prevent any adverse bowel complications, b) review medical records from sending facility prior to readmission in order to properly treat the resident to further	F 684	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance.	9/10/20

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/02/2020

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F 684	Continued From page 1 prevent any adverse bowel and c) develop a comprehensive care plan to assess and monitor bowel function for 1 of 8 residents reviewed (Resident # 5). Resident #5 developed a Exec Order 26 § 4b1 individual's health info action which was diagnosed when the resident was transferred to an acute care hospital for Exec Order 26 § 4b1 individual's health info . This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record of Resident #5 which reflected Resident #5 was initially admitted to the facility on Exec Order 26 § 4b1 individual's hea [redacted]. The Annual Minimum Data Set (MDS), an assessment tool, dated Exec Order 26 § 4b1 individual's health info [redacted] The MDS also indicated that the resident received all their Exec Order 26 § 4b1 individual's health info [redacted] The surveyor reviewed the Physician's Order Sheet (POS) and noted active orders as of 04/01/20 for: Exec Order 26 § 4b1 individual's health info [redacted]	F 684	Resident number five□s care plan was updated to include Exec Order 26 § 4b1 individua [redacted]. Resident number five was evaluated for constipation. All residents at risk for constipation have the potential to be affected. Licensed nurses reviewed computer clinical alerts to identify residents who have triggered for constipation and/or no bowel movement in three days to ensure they have not been affected by the deficient practice. Residents who are at risk for constipation or who have a diagnosis of constipation have been reviewed and comprehensive care plans are in place. Licensed nurses were in-serviced on assessing and monitoring Exec Order 26 § 4b1 individual's he [redacted] Computer clinical alerts will be reviewed to identify residents who have not had a Exec Order 26 § 4b1 individual's health [redacted]. Certified nursing assistants were in-serviced on Exec Order 26 § 4b1 individual's [redacted]. A policy for a Exec Order 26 § 4b1 individual's [redacted] was implemented. Medical records from sending facilities will be reviewed by the Director of	

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F 684	Continued From page 2 Exec Order 26 § 4b1 individual's health info . A review of the April 2020 Medication Administration Record (MAR) reflected documentation that the resident received both the Exec Order 26 § 4b1 individual's health info as ordered. A review of the resident's comprehensive care plan revealed no documentation related to constipation or interventions to Exec Order 26 § 4 . A review of the progress notes dated 4/27/10 at 12:27 AM, revealed that Resident #5 had a Exec Order 2 . The medical doctor (MD) was notified and ordered the resident sent to Emergency Department, next of kin were notified, 911 was called, and resident was sent to the acute care hospital and admitted with Exec Order 26 § . The Universal Transfer Form sent to the hospital with the resident listed as the reasons for transfer as a Exec Order 26 § 4b1 individual's health info . The resident was readmitted to the Long-Term Care (LTC) facility from the acute hospital on Exec Order 26 § 4b1 i A review of the resident's Readmission History and Physical (H&P) by the attending physician, dated Exec Order 26 § 4b1 at 10:38 PM, revealed the resident was readmitted to the facility after an Exec Order 26 § 4b1 individual's health info The H&P further revealed the resident had tested Exec Order 26 § 4b1 individual's health in and the	F 684	Nursing or the designated Nurse and Medical Physician/Nurse Practitioner upon admission. The Director of Nursing or a Registered Nurse will continue the in-services weekly x four weeks. The results will be reviewed at the Quality Assurance Performance Improvement Meetings Quarterly. The Nursing Home Administrator/Designee will conduct an audit to ensure that medical records from sending facilities are reviewed by the Director of Nursing or a Nurse and Physician/Nurse Practitioner. This audit will be conducted weekly x four weeks, then monthly x three months, and then quarterly x three quarters. The results will be reviewed at the Quality Assurance Performance Improvement Meetings Quarterly. The Director of Nursing or a Registered Nurse will audit new admission care plans weekly x four weeks, then monthly x three months, and then quarterly x three quarters to ensure residents who are at risk for Exec Order 26 § 4b1 individ have been reviewed and comprehensive care plans have been updated. The results will be reviewed at the Quality Assurance Performance Improvement Meetings Quarterly.	

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resident was unable to provide any history as Exec O [redacted] Under the assessment section the MD included assessments of "Exec Order 26 § 4b1 individual's health info [redacted] The H& P failed to contain documentation that the admitting physician was aware that while hospitalized the resident had been treated for a Exec Order 26 § 4b1 individual's health info [redacted]

A review of physician's progress notes faxed from the acute care hospital to the facility for clinical review and dated Exec Order 26 § 4b1 at 12:09 PM, revealed a Exec Order 26 § 4b1 individual's health info with contrast report that revealed resident #5 an Exec Order 26 § 4b1 individual's health info [redacted] was noted throughout the 70 pages of the acute care physicians' progress notes

The surveyor requested Exec Order 26 § 4b1 individual's health [redacted] from the acute hospital. The surveyor received and and reviewed the following:

Exec Order 26 § 4b1 individual's health info [redacted]

Exec Order 26 § 4b1 individual's health info [redacted]

performed on 4/29/20 at 10:21 AM results: There is extremely Exec Order 26 § 4b1 individual's health info [redacted] which ascends into the upper

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Exec Order 26 § 4b1 individual's health info . Exec Order 26 § 4b1 individual's health info

Exec Order 26 § 4b1 individual's health info

The surveyor reviewed the facility's progress notes leading up to the resident's hospitalization dated Exec Order 26 § 4b1 individual's . There was no documentation from the nurses or physicians that the resident's Exec Order 26 § 4b1 individual's heal h info A Physician's note dated 04/14/20 at 4:20 AM documented that the resident had resolving Exec Order 26 § 4b1 individual's hea th info

During a tour of the NJSA 47 1A-1 reasonab on 08/12/20 at 11:37 AM, the surveyor observed Resident #5 in bed with the head of bed elevated Exec Order 26 § 4b1 individua The resident was awake and alert.

On 08/12/20 at 11:48 AM, the surveyor interviewed Certified Nursing Assistant #3(CNA#3) who stated that if a resident had a Exec Or the CNA would document in the computer's Point of Care (POC) system and only the CNA's document the Exec Order 2 in the POC system.

On 08/12/20 at 12:26 PM, the surveyor interviewed the Registered Nurse (RN #1) who

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stated that the CNA's document if a resident had or did not have a Exec Or each shift in the computer. RN #1 also stated that the if the resident did not have a Exec Order 26 § 4b1 individual's health info notify the doctor and document in the progress notes.

On 08/12/20 at 1:17 PM, the MD stated that she documents on all LTC residents on a monthly basis and Subacute Rehabilitation residents twice a week.

On 08/12/20 at 2:06 PM, the surveyor interviewed RN #2 who stated that she was assigned to Resident #5 several times prior to Exec O transfer to the acute hospital. RN #2 stated that Resident #5 was Exec Order 26 § 4b1 individual's health info RN #2 also stated that the CNA's documented any Exec Order in the computer. RN#2 then stated "the resident never had an issue with Exec Order 26 § 4b1 individ on the days I was Exec O nurse. If I suspected the resident was having a problem with Exec Order 26 § 4b1 ind, I would have checked Exec Order 26 § 4b1 individual's health."

On 08/17/20 at 08:42 AM, the surveyor interviewed LPN #1 who stated that she would ask the CNA if the resident had a Exec Or. LPN #1 stated that the CNA's document if the resident had a Exec Or or not in the POC system. If a resident did not have a Exec Order 26 § 4b1 individual's health in, then she would call the doctor and document in the progress notes. The LPN then stated that she would check the Exec Order 26 § 4b1 individual's health info. The LPN stated she did not have Resident #5 as a patient in April 2020.

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On 08/17/20 at 08:56 AM , the surveyor interviewed The RN Unit Manager (RNUM) for NJSA 47 1A-1 reasonab who stated that the CNA's document in the POC system if a resident had a Exec Ord or not each shift. The RNUM stated that the computer would alert the nurse if the resident did not have a Exec Order 26 § 4b1 individual's health info and the nurse would then notify the doctor.

On 08/17/20 at 11:27 AM, the surveyor interviewed the Nurse Practitioner (NP) who stated that if a resident did not have a Exec Ord in 3 days she would check to see if Exec Order 26 § 4b1 individual's . She would check the physician's orders to see if the resident was getting any Exec Order 26 § 4b1 individual's health info if needed. The NP stated that if a resident had a Exec Order 26 § 4b1 individual's h the resident could have Exec Order 26 § 4b1 individual's health info .

On 08/17/20 at 12:47 PM, the surveyor interviewed CNA #3 who stated CNA's on all 3 shifts (7am-3 pm, 3 pm to 11 pm and 11 pm to 7am) were to document if a resident had a BM or not on their shift. The CNA stated that the nurse can access the Exec Ord documentation in the POC.

On 08/17/20 at 12:51 PM, the surveyor interviewed CNA #2 who stated CNA's document the resident's Exec Order 26 § 4b1 individual's health in the computer on all 3 shifts. CNA #2 stated if there were any changes in the resident's Exec Order 26 § 4b1 individual's health , such as color or size, she would notify the nurse.

On 08/17/20 at 12:55 PM, the surveyor interviewed CNA #4 who stated the CNA's would document Exec Order 26 § 4b1 individual's health in and describe them in the computer. CNA #4 stated she would notify

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the nurse if the resident did not have a Exec Or.

On 08/17/20 at 3:03 PM, the surveyor interviewed LPN #3 who stated that Resident #5 did not have any issues with Exec Order 26 § 4b1 individual's h at least daily or every other day on her shift. LPN #3 further stated that the CNA documents any Exec Order 2 in the computer. LPN #3 was not sure if the computer would alert the nurse if the resident did not have a Exec Or documented in a 3 day period. The LPN stated she did not remember the resident having any problems with Exec Order 26 § 4b1 individual's health in.

A review of the Point of Care (POC) legend, dated 4/15/20-4/30/20, included the following documentation for Exec Order 26 § 4b1 individual's health in:
" 04/18/20-blank documentation for all 3 shifts
" 04/19/20-No Exec Ord documented at 11:02 AM and 10:59 PM
" 04/21/20-No Exec Or documented at 10:49 PM and 10:39 PM
" 04/22/20 -No Exec Ord documented at 11:53 AM
" 4/24/20 -No Exec Or documented at 1:39 PM
" 04/25/20- No Exec Or documented at 10:16 PM
" 04/26/20- No Exec Or documented at 11:08 AM

On 8/17/20 at 3:28 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed that the POC Exec Order 26 § 4b1 individual's health legend is completed by the CNA's. The DON stated that the CNA's are to document if a resident had a Exec Order 26 § 4b1 individual's health info in the computer each shift. The surveyor reviewed the POC legend form 4/15/20- 4/30/20 with the DON who confirmed that a #2 documented in the legend indicated NO Exec Or and that the CNA's did not document on all 3 shifts. The DON confirmed the above dates that

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the CNA's documented Resident #5 did not have a Exec Or for that date. The DON stated the facility did not have a Exec Order 26 § 4b1 individual's policy.

A review of a facility's "Bowel and Bladder Evaluation" policy, with a revision date of 02/2020, revealed the policy's purpose is to ensure that the resident who is incontinent receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder and bowel function as possible. Under Procedure V, the policy reflected the Interdisciplinary Team (IDT) will develop a care plan that addresses strategies to effectively manage incontinence and constipation (e.g. fluid intake changes, medication review, stool softeners, bowel routines etc.). The care plan will be evaluated at least quarterly and more frequently as required based on the resident's condition in collaboration with the IDT.

The resident was readmitted to the Long-Term Care (LTC) facility from the acute hospital on Exec Order 26 § 4b1. A review of the resident's Readmission History and Physical (H&P) completed by the attending physician, dated Exec Order 26 § 4b1 at 10:38 PM, revealed the resident was readmitted to the facility after an acute hospitalization for Exec Order 26 § 4b1 individual's health info The H&P further revealed the resident had tested Exec Order 26 § 4b1 indivi and the resident was unable to provide any history as he was essentially Exec Order 26 § 4b1 ind. The

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H&P failed to contain documented evidence that the admitting physician was aware that the resident was treated for a Exec Order 26 § 4b1 individual's h when hospitalized.

On 8/13/20 at 2:38 PM the DON provided records from the sending acute hospital for the admission on Exec Order 26 § 4b1. The Universal Transfer Form or transfer medication list were not included in these records. These records included progress notes from the MD at the acute hospital dated Exec Order 26 § 4b1 individual's health in and printed on the top of each of the 70 pages were the words 05/13/20 at 12:28 PM Fax Server. The surveyor reviewed these progress notes and noted the following:

Exec Order 26 § 4b1 individual's health info

Exec Order 26 § 4b1 individual's health info

Throughout the progress notes from the acute hospital there was documentation of Exec Order

The surveyor requested radiology reports from the acute hospital and and when received reviewed the following:

Exec Order 26 § 4b1 individual's health info

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F 684	Continued From page 10 12:47 AM results: Exec Order 26 § 4b1 individual's health info Exec Order 26 § 4b1 individual's health info Exec Order 26 § 4b1 individual's health info . The surveyor reviewed the facility's May 2020 POS for Resident #5 and noted an order for Exec Order 26 § 4b1 individual's health info A review of the resident's comprehensive care plan did not include that the resident had Exec Order 26 § 4b1 individual's health info A review of the Admission/Readmission Nursing Evaluation dated Exec Order 26 § 4b1 at 3:28 PM , under Exec Order 26 § 4b1 individual's health , the RN #2 documented that the resident was Exec Order 26 § 4b1 individual's health info	F 684		

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On 08/17/20 at 8:42 AM, the surveyor interviewed LPN #1 who stated that when a resident is admitted to the facility, the sending hospital would call a report to the nurse that was assigned to the admission. The LPN stated that the RN reviewed the records that were sent form the sending facility and the LPN reviewed the medication list.

On 08/17/20 at 8:57 AM, the surveyor interviewed the RNUM who stated that if the resident is hospitalized greater than 24 hours, the resident was considered a new admission and would need new orders and assessments. The nurse who was assigned the admission would get a verbal report from the sending hospital and this report is not part of the medical record. The UMRN stated that sometimes the hospitals don't always send the Universal Transfer Form (UTF) or the medication record and the nurse would need to call the sending facility to obtain these records. The UMRN stated that the admissions department would send an email to notify the nurse of the admission and if the resident would need special equipment. The UMRN further stated that the facility's liaisons would get the referral records from the hospital and the DON or Regional Nurse would review the records before readmitting the resident. The UMRM also stated that she had spoken with the residents' NJSA 47 1A-1 reaso after NJSA was readmitted, and the NJSA 47 1A-1 reaso gave her an update on the resident's hospitalization stay. The RNUM stated that the NJSA 47 1A-1 reaso informed her that the resident had a Exec Order 26 at the hospital but when she reviewed the records she did not see any documentation of a Exec Order 26 § 4b1 individual's h in the records sent by the hospital. The NJSA 47 1A-1 reaso requested medication and

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the UMRN called the doctor and received an order for Exec Order 26 § 4 The UMRN stated that if she was aware the resident had a history of a Exec Order 2 then a care plan would have been initiated.

On 08/17/20 at 12:20 PM, the surveyor interviewed the Medical Director (MD) who stated that the facility would receive records from the sending hospital, and it varied what records were sent. The MD stated Resident #5 was readmitted with a diagnosis of Exec Order 26 § 4b1 individual's health and cannot recall reviewing any records noting Resident #5 was treated for a Exec Order 26 § 4b1 individual's h. The MD stated " My guess is the resident came with a super thin record with no mention of a Exec Order 26 § 4b1 individual's h. If I had known the resident had a history of a Exec Order 26 § 4b1 individual's h, I would have made sure the resident was on a bowel regimen."

On 08/17/20 at 12:45 PM, a surveyor interviewed the DON who stated that an external liaison would receive referrals for new admissions and re-admissions and would review the medical records to determine if a resident would need special medical equipment. The DON will review the medical aspect of the medical record for readmissions. The DON stated she would review the H&P, imaging reports. Lab reports, and medication list and would determine if the facility can accept the resident. The DON further stated that usually if a resident is readmitted or admitted without medical records, the facility would request the records. The DON stated " I don't know why Resident #5's medical information from the hospital about the resident experiencing a Exec Order 26 § 4b1 individual's h was not communicated. If I knew the resident had a Exec Order , I would have looked into it."

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On 8/17/20 at 2:18 PM, the DON provided a copy of the incomplete Referral Review Sheet dated 5/13/20 which did not contain a clinical acceptance date.

On 08/17/20 at 2:20 PM, the surveyor interviewed Resident #5's NJSA 47 1A-1 reaso via telephone who stated she spoke with the RNUM a few days after the resident was readmitted and informed her that the Emergency Room doctor told her that the resident was admitted for a Exec Order . The NJSA 47 1A-1 reaso stated she informed the RNUM about her concerns of the Exec Order 26 § 4b1 individual's h.

On 8/17/20 at 3:13 PM, the surveyor interviewed the External Liaison #1 (EL #1) who stated she was not a clinical liaison so only reviewed referrals to determine if special medical equipment was needed. The EL#1 stated that any referrals' medical records then would be sent to the DON or Nursing to review prior to admitting to facility and once the medical records were reviewed by the DON or Unit manager, an approval would be written on the referral sheet. EL#1 stated all referral's medical records are uploaded into the computer by the admissions department.

On 8/17/20 at 3:28 PM, the surveyor interviewed the DON and the Administrator (LNHA) in the presence of the survey team. The DON stated that she could not remember who reviewed the resident's referral medical records. The DON further stated that Resident #5 was their resident previously so they would readmit him/her. The DON further stated that if she knew the resident had a Exec Order 26 § 4b1 individual's h then she would have

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started an investigation. The DON confirmed that the resident should have had a care plan for Exec Order 26 § 4b1 individ and that she did not know who looked at or reviewed the paperwork that was faxed on 5/13/20 prior to the resident's admission on Exec Order 26 § 4b

On 8/18/20 at 9:17 AM, the surveyor interviewed the Administrator (LNHA) who stated that Resident #5 was previously a resident of their facility, was known to them and we would readmit the resident The LNHA stated the external liaisons would receive a referral from the hospital and review the records to see if any special equipment was needed for an admission. The records would then be reviewed by clinical such as the DON or Unit Manager. The LNHA further stated that the facility was in the middle of the Covid pandemic and everything was turned upside down. The LNHA confirmed that the MD did not see the records from the hospital dated 5/13/20 and did not know who reviewed the medical records prior to readmission.

On 8/18/20 at 9:32 AM, the DON stated the records dated 5/13/20 were not faxed to her and she never reviewed them.

On 8/18/20 at 11:05 AM, the surveyor interviewed the Minimum Data Set (MDS) Coordinator who stated she completed the annual MDS on Exec Order 26 §. The MDS coordinator stated she only reviewed the H&P and the UTF but did not review the hospital records (dated Exec Order 26 § 4b1 individual's health info

On 8/18/20 at 1:03 PM the DON stated she could not confirm what records came with the resident

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on the readmission date of Exec Order 26 § 4b

On 8/18/20 at 2:15 PM, the surveyor interviewed EL#2 via telephone who stated that he was not a clinical liaison and he did not get the paperwork from the acute hospital but that the referral paperwork was faxed directly to the facility. EL#2 could not remember if he received a call from the acute hospital that the resident was ready to be admitted. EL#2 stated that the RN or DON would review all paperwork faxed to the facility prior to admission.

On 8/19/20 at 4:11 PM, the surveyor conducted a post survey interview with LPN # 4 who stated she could not remember what paperwork came with the resident on the readmission date of 5/18/20. LPN #4 stated she did get report from the sending facility but knew this resident and knew what the resident needed because of the previous admission and she had set up the room with any equipment that was needed. LPN #4 further stated that she was told the resident went out for respiratory distress and was not aware the acute care hospital treated the resident for a Exec Order 26 § 4b1 individual's h. The LPN #4 stated that she would review the medications and verify the medication with the doctor, but the RN would do the assessment and did not remember who received report from the sending hospital for this resident.

A review of a facility's "Admission and Orientation of Residents" policy with a revision date of 02/2020, revealed that the eligibility for admission will be determined by the Administrator and Director of Nursing Services and admissions will be determined by a professional assessment/evaluation of the

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F 684	Continued From page 16 resident's condition and needs, the skills and abilities of facility and staff to meet those needs and the Attending Physician's prescribed course of treatment. NJAC 8:39-27.1(a)	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00137702 Based on interview, record review, and other pertinent facility documents, it was determined that the facility failed to follow standard operational procedures in accordance with the facility policy for a resident with weight loss of	F 692	Submission of this Plan of Correction does not constitute an admission or agreement by the provider on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this plan of	9/10/20

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F 692	Continued From page 17 five pounds or more for 1 of 1 resident reviewed for nutritional status, (Resident #6 - closed record). This deficient practice was based on the following: The surveyor reviewed the Admission Record contained within the closed record of Resident #6, which revealed that the resident was admitted to the facility on Exec Order 26 § 4b1 individual's health info [redacted] The resident also had an Exec Order 26 § 4b1 individual's health info [redacted] The surveyor interviewed the Nurse Practitioner on 8/17/20 who described the Exec Order 26 § 4b1 individual's hea [redacted] According to the Nurse Practitioner the resident had Exec Order 26 § [redacted] Resident #6 was discharged to an acute care hospital o Exec Order 26 § 4b1 individual's health info [redacted] The resident did not return to the facility. Review of the admission Minimum Data Set (MDS) (functional assessment tool) with an assessment reference date of Exec Order 26 § 4b1 individual's health info [redacted] with	F 692	correction as our credible allegation of compliance. Resident number six no longer resides at the facility. All residents have the potential to be affected by the deficient practice. A weight exemption report was retrieved for the last 30 days. Residents in the facility who triggered for weight loss were evaluated by the dietician to ensure they were re-weighed if needed and evaluated. The dietician or licensed nurse will review the computer clinical alerts and weight exemption report to identify residents with weight loss and they will be evaluated. The physician will be notified of significant weight changes. The dietician and licensed nurse will review weekly weights to ensure compliance with the facility□s weight management policy. The dietician or licensed nurse will review the results of the computer clinical alerts as well as weekly weight compliance weekly x four weeks, then monthly x three months, and then quarterly x three quarters to ensure residents who trigger are evaluated. The results will be reviewed at the Quality Assurance Performance Improvement Meetings Quarterly.	

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unclear speech and was sometimes understood. Further review of the MDS revealed that the resident required supervision with ambulation and eating.

The surveyor reviewed the Nutrition Assessment of Resident #6 dated 06/08/20, which revealed that on 06/06/20 the resident was Exec Order 26 § 4b1 individual's [redacted] and was determined to be underweight with a desired body weight of Exec Order 26 § 4b1 individu [redacted] The Dietician documented that the resident's hospital weight prior to admission was Exec Order 26 § [redacted] and the resident weighed Exec Order 26 § [redacted] at the facility which appeared to be accurate. The Dietician noted that weekly weights were ongoing according to the facility's admission policy. The Dietician's Nutrition Diagnosis was: Nutritional risk related to low BMI, pacing in the hallways, at risk for skin breakdown and need for a modified diet (dysphagia advanced with nectar liquids). Further review of the Assessment revealed that the goal for the resident was weight gain and nutrition monitoring which included: weight, skin and tolerance of diet. The Dietician specified that the resident would receive snacks twice daily.

The surveyor reviewed Resident #6's Care Plan which contained an entry for Exec Order 26 § 4b1 individual's health info [redacted] The goal was for the resident to maintain present weight plus five pounds, and to consume at least 50% of most meals and 75% of fluids and and supplements/snacks offered.

The surveyor reviewed Resident #6's Order

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Summary Report which contained an order written on 06/05/20 for Weight on Admission and Weekly for 4 weeks every day shift every 7 days for 28 days.

A review of the Weights and Vitals Summary revealed that on 06/06/20 Resident #6's standing weight was Exec Order 26 § and on 06/20/20 the resident's weight was Exec Order 26 § 4 sitting, a loss of Exec Order 26 § 4.

The surveyor reviewed the Medication Administration Record which revealed that Resident #6's weight on 06/13/20 was Exec Order 26 § and on 06/27/20 the resident's weight was not documented in the space allotted.

On 08/17/20 at 9:10 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that when she was previously assigned to Resident #6 she weighed the resident in the chair. She stated that she would have reported weight loss to the nurse if noted. The CNA stated that she would have also told the nurse if the resident refused to eat or be weighed.

On 08/17/20 at 9:22 AM, the surveyor interviewed Licensed practical Nurse #1 who stated that if she identified resident weight loss she would notify the Unit Manager, Physician and Dietician of a red flag weight loss of three lbs or more. She further stated that the aides were required to inform nursing of the amount of food consumed so that nursing could document it.

On 08/17/20 at 9:33 AM, the surveyor interviewed CNA #2 who stated that Resident #6 frequently walked around the facility and never

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really ate much. She stated that the resident was fed by staff if the resident permitted. She further stated that the resident was weighed on the standing scale but she was not aware of any weight loss.

On 08/17/20 at 9:45 AM, the surveyor interviewed the Registered Dietician (RD) who stated that she reviewed Resident #6's hospital records which identified that the resident weighed Exec Order 26 § 4 She stated that the resident's admission weight at the facility was Exec Order 26 § 4 She stated that if she noted a discrepancy in the preadmission weight and the admission weight she would; visually look at the resident and see if the admission weight appeared to be accurate as she documented in her Nutrition Assessment. She further stated that the facility policy would then require that a weekly weight was done for four weeks. The RD stated that if a resident weight increased or decreased by 5 lbs a reweigh was required to verify accuracy.

The RD stated that unless something came up she would follow-up with the resident monthly and she was not notified that on 06/20/20 that Resident #6 weighed Exec Order 26 § 4. The RD calculated that the Resident #6's change in weight from Exec Ord to 95.5% was considered a significant weight loss of 16%. She further stated that the first thing that she would have done was obtain a re-weigh to confirm accuracy. She stated that if nursing entered the weight they should have also verified the weight for accuracy as two different scales were used (sitting versus standing). The RD reviewed the Progress Notes dated 6/20/20 and confirmed that there was no documented evidence that the nurse who entered the weight notified both the doctor and the physician as

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required for a weight loss greater than 5 lbs in accordance with facility policy. The RD further stated that she ordered the resident peanut butter and jelly sandwiches at 2 PM and 7 PM daily for snack on initial assessment.

On 08/17/20 at 10:59 AM, the surveyor interviewed the Director of Social Services (DOSS) who stated that Resident #6 had behaviors which included combativeness and refusal of care. She stated that the resident liked to walk around the building and refused to eat. She stated that the administrative team distributed trays and she knew who was eating and who wasn't. She stated that she tore the ticket on the tray in half and told the aides that the resident wasn't eating as the aides were required to document meal consumption. She further stated that she did not inform the nurse.

On 08/17/20 at 11:39 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that the facility held a meeting every Friday with the dietician to review weekly weights. She stated that the aides obtain the weights and the nurses document the weights in the computer. She stated that during COVID the weight meetings were not held but they were held during the month of June. She stated that staff obtained resident weights early in the day to ensure that the data was available for review.

The RN/UM stated that when a weight was entered into the computer that triggers that there has been a significant change the value appeared on the dashboard of the computer in red and remained red. She further stated that Registered Nurse (RN) who entered the weight of 95.5 lbs on 06/20/20 should have notified the

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medical doctor and her team of the weight. The RN/UM reviewed the Progress Notes and stated that on 06/27/20 LPN #2 documented that he/she was unable to obtain Resident #6's weight because the resident would not stay still to register the weight. The RN/UM stated that LPN #2 should have notified the doctor and the family of the resident's weight loss and his/her inability to obtain a subsequent weight. The RN/UM stated that she was unaware of the resident's weight loss.

On 08/17/20 at 12:18 PM, the surveyor interviewed LPN #2 who stated that if he/she was unable to obtain a resident weight he/she would document it in the Progress Notes and notify the supervisor. He stated that he recalled that some days Resident #6 barely touched his/her meal and tried to stand up and leave when encouraged to eat. LPN #2 stated that some of the aides advised nursing of the amount of food that the resident consumed and some didn't. He/She further stated that he did not recall alerting the dietician or the physician of his/her inability to weigh the resident or resident's weight loss and poor appetite.

On 08/17/20 at 12:40 PM, the surveyor interviewed the Medical Doctor who stated that Resident #6 had a mass on his/mouth and had cancer. She stated that she didn't remember specific notification of weight loss and nursing should call us to report weight loss or inability to obtain a weight. She stated that at least if nursing would have let us know and documented it the Nurse Practitioner would have given a discharge order to send the resident out to the hospital.

On 08/17/20 at 1:45 PM, in a later interview with

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the RD, she stated that she wasn't advised of Resident #6's weight loss and did not discuss the resident's weight loss at the weekly meeting.

On 08/17/20 at 02:20 PM, the Director of Nursing (DON) furnished the surveyor with Resident #6's Look Back Report which contained the percentage of meals that the resident consumed between 06/05/20 and 06/28/20. On 06/07/20, 06/16/20, 06/18/20, 06/21/20, 06/27/20 and 06/28/20 no food intake was recorded. Further review of the document revealed that on 06/14/20 only one meal observation was recorded. The DON concurred that meal observations were not documented on the aforementioned dates.

On 08/17/20 at 3:30 PM, the surveyor interviewed the DON who stated that Resident #6's admission weight of Exec Order 26 § should have been verified with a reweigh after it was determined that the hospital reported weight for the resident was Exec Order 26 §. She stated that on 06/20/20, when the resident's weight was Exec Order 26 § 4 the nurse should have reweighed the resident, notified the doctor and documented the weight and or resident refusal in the Progress Notes. The nurse who documented the resident's weight of 95.5 lbs was not available for interview.

The DON stated that the CNA's were expected to document the percentage of each meal consumed by the resident at breakfast, lunch and dinner. She further stated that the Look Back Report should not have contained blanks and should accurately document the amount of food that the resident consumed.

The surveyor reviewed the facility policy,

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"Assessment and Management of Resident Weights" (Reviewed/Revised: 06/2020) which revealed the following:

Purpose:

To ensure that each resident maintains acceptable parameters of weight and nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible based on the resident's comprehensive assessment. To ensure that a resident receives a therapeutic diet when there is a nutritional problem.

Weights are obtained upon admission and/or readmission, then weekly for four (4) weeks and monthly thereafter. Additional weights may be obtained at the discretion of the licensed nurse or the interdisciplinary team (IDT).

If the weight is less than or greater than 5# from the previous weight, immediately re-weigh and have licensed nurse verify the accuracy of the weight.

Weights will be entered into the clinical record oncethe weight is reviewed by a licensed nurse.

Significant weight changes will be revived by the DNS or designated licensed nurse. Significant weight changes are:

i. 5% in one (1) month
ii. 7.5% in three (3) months
iii. 10% in (6) months.

The DNS or licensed nurse will:
i. Notify the physician, dietician and responsible

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNWOOD REHABILITATION AND HEALTHCARE CENTER	**1700 WYNWOOD DRIVE CINNAMINSON, NJ 08077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 25 party of significant weight changes; ii. Document notification in the nurses' notes. The Registered Dietician will: i. Complete a nutritional assessment all residents with a significant weight change; a ii. Document the nutritional assessment and weight management recommendations in the medical record. The licensed nurse will notify the physician of the dietician's recommendations and notify the family/health care decision maker of the significant weight change, as indicated. NJAC 8:39-27.2(a)	F 692		