STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315149	A. BUILDING _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

(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 Standard Survey: 06/06/2019 Census: 95 Sample Size: 19 + 3 closed, 26 MDS The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		7/8/19

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

Electronically Signed | 07/05/2019

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to promote residents dignity by serving cold beverages in disposable cups in the dining room. This deficient practice was identified for 19 of the 27 residents in the main dining room and then again on a separate occasion for 19 out to the 25 residents served in the main dining room and was evidenced by the following: On 05/02/19 at 12:38 PM, the surveyor observed 27 residents in the main dining room for lunch. Of the 27 residents, 19 residents were served cold beverages in disposable plastic drink cups prior to the lunch trays being served. On 05/05/19 at 12:20 PM, the surveyor observed 25 residents in the main dining room for lunch. A pink cold beverage was served to 19 of those residents in white Styrofoam cups prior to the lunch trays being served.	F 550	F550 1. The Disposable cups that were used to serve the residents in the main dining room were discontinued. New non-disposable cups were provided so that the residents can be served with dignity. 2. All residents are affected by this deficient practice. To serve the residents in disposable cups is not dignifying and affects their quality of life. 3. An in-service was done with the kitchen staff and the food service director as to the residents dignity and quality of life. They were instructed not to serve any residents In disposable cups. 4. The food service director and the administrator will monitor this deficient practice on a daily basis to assure That	

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F 550	Continued From page 2 During an interview with the surveyor on 06/05/19 at 1:30 PM, the Dietary Director stated that before the food carts come out of the kitchen, cold beverages are served in a disposable cups. The Dietary Director stated that as far as she knows this is how it has always been. The Dietary Director stated that there are no other cups for the residents except for the hot beverage cups. The surveyor requested the facility's policy and procedure. The Dietary Director stated that the facility did not have one. During an interview on 06/06/19 at 09:00 AM, the facility owner stated that he was not aware plastic disposable cups were being used to serve drinks. The facility was unable to provide a policy and procedure for serving food to residents in the dining room. NJAC 8:39-17.2(e)	F 550	this practice does not reoccur. All findings will be reviewed by the quarterly quality insurance committee.	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		7/8/19

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F 640	Continued From page 3 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to transmit the Minimum Data Set (MDS-an assessment tool), within 14 days of completing	F 640	F-640 1. The 26 residents that were identified with assessments that were completed	

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F 640	Continued From page 4 the resident's assessment. This deficient practice was identified for 26 of 26 residents with 57 MDS' reviewed for late submissions and was evidenced by the following: The surveyor reviewed the MDS "Assessment Schedule Completion Dates" print outs for all 26 residents that had been provided by the facility MDS Coordinator Licensed Practical Nurse (LPN). The print outs revealed the MDS submission due date and the actual submission date of each the 57 MDS'. The print outs provided revealed that the MDS' had not been submitted 14 days from their completion date or by the submission due date. The MDS "Assessment Schedule Completion Dates" print outs revealed the MDS' were submitted late for the following: four (4) discharge MDS'; one (1) entry MDS; one (1) significant change MDS; six (6) annual MDS' and 45 quarterly MDS'. During an interview conducted by the surveyor on 06/06/19 at 08:10 AM, the MDS Coordinator LPN stated she had been aware there was a time limit to submit and that she would reference the submission due by date provided. The MDS Coordinator LPN stated she had been aware the submissions were late. Review of the facility, "Electronic Transmission of the MDS' policy dated reviewed 01/16/19 that revealed the MDS information should be transmitted in accordance with current OBRA (Omnibus Budget Reconciliation Act - a process to set standards of care) regulations. Review of the Resident Assessment Instrument (RAI) 3.0 manual (updated October 2018),	F 640	and submitted late could not be corrected. A new MDS coordinator was hired March of 2019. 2. All residents have the potential to be affected by this deficient practice. An audit was done of all MDS completed and submitted in the past 30 days. None were found deficient. All resident assessments are currently being completed and transmitted on time in accordance with the with RAI guidelines and regulations. 3. An in-service on chapter 5 of the RAI Manual was reviewed with the MDS coordinator. 4. The Regional MDS Director will monitor all MDS completions and submissions from the dashboard ongoing. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

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F 640	Continued From page 5 Chapter 5: Submission and Correction of MDS Assessments, which indicated that the MDS assessments must be submitted within 14 days of the MDS Completion Date. NJAC 8:39-11.2 (e)	F 640		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool for 3 of 19 residents (Resident #6, #57 and #80). This deficient practice was evidenced by the following: 1. On 06/05/19 at 08:07 AM, the surveyor observed Resident #80 lying in bed. According to the Face Sheet, Resident #80 was admitted to the facility on [redacted] with diagnoses including but not limited to; [redacted]. The surveyor reviewed Resident #80's Monthly Vital Signs/Weights sheet and Section K0200 (Height and Weight) of the resident's MDS assessments which revealed the following: The May 2018 monthly weight was recorded as [redacted]) and the June 2018 monthly weight was recorded as [redacted] The	F 641	F-641 1. The MDS for residents # 6,57 and 80 were corrected to accurately reflect the documentation in the resident medical record. The new MDS coordinator was hired in March of 2019. 2. All residents have the potential to be affected by this deficient practice when MDS are not coded correctly. An audit was done for MDS done in the last 30 days and weight information was checked for accuracy. 3. An in-service was done with the MDS coordinator to double check on the weights in the chart for accuracy. 4. The facility MDS coordinator will double check with the DON and ADON the accuracy of all information prior to coding on the MDS that are due each week ongoing. All findings will be reviewed at	7/8/19

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F 641	Continued From page 6 Quarterly MDS, dated [redacted], reflected a weight of [redacted] The September 2018 monthly weight was recorded as [redacted] The Quarterly MDS, dated [redacted] reflected a weight of [redacted] The December 2018 monthly weight was recorded as [redacted]. The Annual MDS, dated [redacted] reflected a weight of [redacted] The February 2019 monthly weight was recorded as [redacted] The Discharge MDS, dated [redacted] reflected a weight of [redacted] The March 2019 monthly weight was recorded as [redacted]. The Quarterly MDS, dated [redacted] reflected a weight of [redacted] The April 2019 monthly weight was recorded as [redacted]. The 5-day MDS, dated [redacted] revealed a weight of [redacted] The 14-day MDS, dated [redacted] revealed a weight of [redacted] The May 2019 monthly weight was recorded as [redacted]. The 30-Day MDS, dated [redacted] reflected a weight of [redacted] 2. On 05/29/19 at 10:49 AM, the surveyor observed Resident #6 in a wheelchair. The surveyor attempted to interview the resident; however, he/she was unable to answer questions. According to the Face Sheet, Resident #6 was admitted to the facility on [redacted] with diagnoses which included [redacted]	F 641	the Quality Assurance meeting x 3 quarters.	

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F 641	Continued From page 7	F 641		

Review of the Quarterly MDS, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted]

Review of an Incident/Accident Report, dated 05/29/18, reflected an unwitnessed fall in the resident's room whereby the resident sustained a [redacted] was done which reflected [redacted].

Review of the Quarterly MDS, dated [redacted] reflected in Section J that there were no falls since the prior assessment.

Review of an Incident/Accident Report, dated 03/13/19, reflected a witnessed fall in the resident's room. There was no documentation of injury.

Review of an Incident/Accident Report, dated 03/17/19, reflected a witnessed fall in the resident's room. There was no documentation of injury.

Review of an Incident/Accident Report, dated 03/30/19, reflected a fall in the dining room. There was no documentation of injury.

Review of an Incident/Accident Report, dated 04/10/19, reflected a witnessed fall in the resident's room. There was no documentation of injury.

Review of the Quarterly MDS, dated [redacted], reflected in Section J that there were no falls since the prior assessment.

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F 641	Continued From page 8 3. On 05/29/19 at 10:42 AM, the surveyor observed Resident #57 in a wheelchair. The resident presented with [redacted] of the wheelchair. During an interview at the resident stated that he/she had [redacted] According to the Face Sheet, Resident #57 was admitted to the facility on [redacted] with diagnoses which included but not limited to; [redacted] Review of the resident's August 2018 monthly weight was recorded as [redacted] The discharge - return anticipated MDS, dated [redacted] reflected a weight of [redacted] Review of the resident's September 2018 monthly weight was recorded as [redacted] The Quarterly MDS, dated [redacted], reflected a weight of [redacted] Review of the resident's March 2019 monthly weight was recorded as [redacted] The Quarterly MDS, dated [redacted] reflected a weight of [redacted] During an interview with the surveyor on 06/05/19 at 1:40 PM, the Regional Nurse Manager stated that the weights in the chart on the weight sheet should have been reflected in the MDS, there should not have been a discrepancy.	F 641		

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F 641	Continued From page 9 During an interview with the surveyor on 06/06/19 at 8:29 AM, the MDS Coordinator stated that she gathers MDS information from the resident's medical record and inputs the information into each MDS section. The MDS Coordinator stated the weights from the weight sheet on the resident's chart should be used to code the weight on the MDS. NJAC 8:39-11.1(e)(1)	F 641		
F 656 SS=E	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 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	F 656		7/8/19

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F 656	Continued From page 10 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: Based on observation, interview and record review, it was determined that the facility failed to ensure the development of an interdisciplinary comprehensive resident-centered care plan with interventions specific for individual residents. This deficient practice was identified for 6 of 19 residents reviewed for develop of comprehensive care plans. (Resident #6, #44, #47, #53, #55, and #291) and was evidenced by the following: 1. On 05/29/19 at 10:10 AM, the surveyor observed Resident #47 lying in bed. The surveyor observed a [redacted] attached to the bed frame. Resident #47 stated to the surveyor that he/she had a '[redacted] According the Face Sheet, Resident #47 was readmitted to the facility on [redacted]. Review of the Nurses Notes, dated 04/21/19, revealed Resident #47 had been readmitted [redacted] from	F 656	1. Resident #47 comprehensive care plan was updated to reflect interventions related to [redacted] esident #6 comprehensive care plan was updated to reflect [redacted]. Resident #44 comprehensive care plan was updated to reflect [redacted]. Resident #291 baseline care plan and comprehensive care plan was updated to reflect interventions related to precautions for [redacted]. Resident #55 comprehensive care plan was initiated to include revisions related to care provided. Resident #53 comprehensive care plan was initiated to include revisions related to care provided. 2. All residents have the potential to be affected by the deficient practice of failing to ensure the development of an	

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F 656	Continued From page 11 the hospital with diagnoses that included but were not limited to; [redacted]. The Nurses Note also revealed that Resident #47 had an [redacted] Review of the "Nursing Admission Assessment" sheet, dated 02/17/19, revealed a [redacted]. Review of the "Nursing Admission Assessment" sheet, dated 03/13/19, revealed a [redacted]. Review of Resident #47's Admission Minimal Data Set (MDS), an assessment tool dated [redacted], revealed [redacted] Review of Resident #47's Admission MDS, dated [redacted], revealed an [redacted]. The surveyor reviewed the [redacted] care nurse's consult sheet, dated 03/15/19, that revealed re-consulted for [redacted]. Review of the "Weekly [redacted] Report," dated 03/26/19, revealed a [redacted]. Review of the [redacted] care nurse consult sheet, dated 04/12/19, revealed a [redacted] Review of a "Nursing Admission Assessment" sheet, dated 05/06/19, revealed Resident #47 had an [redacted].	F 656	interdisciplinary comprehensive resident-centered care plan with specific interventions. Baseline Care Plans will be reviewed by the unit manager to ensure that initiation has occurred within the allotted time frame. Comprehensive Care Plans will be reviewed and updated during the following business day clinical morning meeting for each episodic event and quarterly during interdisciplinary meetings by the unit manager to ensure that episodic events have been captured on the care plan. 3. All clinical managerial nurses were in-serviced regarding developing comprehensive care plans and how it relates to planning and managing resident care as evidenced by documentation from admission through discharge. 4. The DON or designee will monitor weekly that five Baseline Care Plans and Comprehensive Care Plans have been initiated for five months to ensure facility policy and procedures are being followed utilizing the created auditing tool. Findings will be reported at the next quarterly QA meeting.	

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F 656	Continued From page 12 Review of a "Nursing Admission Assessment" sheet, dated 05/27/19, revealed Resident #47 had an [redacted] The surveyor reviewed Resident #47's on-going Interdisciplinary Care Plan, dated 11/29/18. The Care Plan did not address, provide interventions, goals or evaluations for Resident #47's [redacted]. During an interview conducted by the surveyor on 06/04/19 at 11:17 AM, the [redacted] Licensed Practical Nurse (LPN) Unit Manager (UM) stated the nurse or the nurse manager who admits the resident would initiate or update the care plan. She gave examples of information that should be included on the care plan, to include: [redacted] The UM further stated the care areas mentioned should be added to the care plan as soon as a resident is admitted or has an issue. The UM was unable to produce a care plan for Resident #47 that addressed the [redacted] 2. On 05/29/19 at 10:49 AM, the surveyor observed Resident #6 in a wheelchair. The resident had a [redacted] and the resident's [redacted]. The surveyor attempted to interview the resident; however, he/she was unable to answer questions. According to the Face Sheet, Resident #6 was admitted to the facility on [redacted] with diagnoses which included [redacted]	F 656		

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F 656	Continued From page 13 Review of the Quarterly MDS, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted] Review of the Physician's Order (PO), dated 03/26/19, reflected an order that discontinued Occupational Therapy (OT) Services and orders to place a [redacted] on the resident for four hours during the day shift and four hours in the evening shift. It further indicated that if the resident complained of discomfort to contact OT and nursing staff. Review of the PO, dated 03/27/19, reflected an order to place the [redacted] at 08:00 AM, remove at 12:00 PM and to check skin integrity. It further reflected to place the [redacted] at 5:00 PM, remove at 09:00 PM and to check skin integrity again and report all findings to the doctor. Review of the PO, dated 05/09/19, reflected an order clarification for the [redacted] It further indicated to remove the [redacted] for care and meals. Review of the June 2019 Physician's Order Form (POF), reflected the above orders for [redacted], removal and skin integrity checks. Review of the April, May and June 2019 Treatment Administration Records (TARs) reflected the placement, removal and skin integrity checks for the [redacted] and a diagnosis as [redacted].	F 656		

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F 656	Continued From page 14 Review of an OT Evaluation and Plan of Treatment note for a Certification Period, dated 03/05/19 through 04/01/19, reflected an onset date of 12/14/18 for a [redacted] and [redacted]. It further indicated the recommendation for the resident to [redacted]. Review of Rehabilitation Recommendations, dated 05/06/19, reflected that the resident was discharged from OT services on 03/21/19 with a [redacted]. Review of a Medical Progress Note, dated 07/30/18, reflected the resident had [redacted] It further indicated [redacted] of the [redacted]. Review of a Medical Progress Note, dated 08/30/18, reflected the resident had [redacted]). Review of a Medical Progress Note, dated 11/23/18, reflected the resident had [redacted] Review of a Medical Progress Note, dated 03/08/19, reflected the resident had [redacted]. Review of a Medical Progress Note, dated 04/26/19, reflected the resident had [redacted]	F 656		

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[redacted].

Review of a Nurse Practitioners Progress Note, dated 05/17/19, reflected the resident had [redacted]

Review of an [redacted], dated [redacted], reflected an [redacted]

Review of the Interdisciplinary Care Plan, with a review date of 05/15/18, did not reflect evidence of a comprehensive person-centered plan of care in regards to [redacted]

During an interview with the surveyor on 06/05/19 at 10:02 AM, the Director of Therapy stated the resident was seen by OT from 03/05/19 through 04/01/19 related to [redacted] and that the resident had a [redacted] The Director of Therapy further stated that the resident had [redacted] She also stated that once a resident was discharged from therapy, a care plan should have been initiated and that nursing updated the care plans thereafter.

During an interview with the surveyor on 06/03/19 at 10:25 AM, the Certified Nursing Assistant (CNA) stated that the resident wore a [redacted] and that he/she sometimes removed it and the [redacted].

During an interview with the surveyor on 06/05/19 at 10:53 AM, the LPN medication nurse #1 stated

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F 656	Continued From page 16 that the resident [redacted] and was aware the resident had [redacted] During an interview with the surveyor on 06/05/19 at 1:27 PM, the Regional Nurse Manager stated that the use of a [redacted] should have been reflected in a care plan specifically under [redacted] and that nursing was in charge of updating the [redacted] care plans. During an interview with the surveyor on 06/05/19 at 1:51 PM, in the presence of the Director of Nursing and the Assistant Director of Nursing (ADON), the Regional Nurse Manager stated that the [redacted] should have been reflected in the resident's care plan. The ADON stated that the [redacted] was used to [redacted]. 3. On 05/30/19 at 10:49 AM, the surveyor observed Resident #44 in a high back wheelchair at lunch being fed by nursing staff. The resident had a [redacted] on the [redacted] with the [redacted] According to the Face Sheet, Resident #44 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] Review of the Annual MDS, dated [redacted] reflected that the resident had a BIMS which [redacted] Review of the Annual MDS, dated [redacted] the	F 656		

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F 656	Continued From page 17 Care Area Assessment Summary indicated a Care Planning Decision for Nutritional Status and Dehydration/Fluid Maintenance. Review of the June 2018 POF reflected the following: A diagnosis of [redacted]. A diet order for Pureed food and Nectar Thickened Liquids, since 03/13/12. An order for 240 milliliters (mLs) of Nectar Thickened Liquids every shift, since 03/13/12. An order for 120 mLs of a [redacted] supplement twice a day, since 02/21/17. Review of the June 2019 POF reflected the following: A diagnosis of [redacted]. A diet order for Pureed food and Nectar Thickened Liquids, since 03/13/12. An order for 240 milliliters (mLs) of Nectar Thickened Liquids every shift, since 03/13/12. An order for 120 mLs of a [redacted] supplement twice a day, and at bedtime, since 04/23/19. Review of an Advanced Practical Nurse (APN) Progress Note, dated 10/08/18, reflected the resident had a diagnosis of [redacted]. Review of Medical Progress notes, dated 01/21/19, 03/08/19 and 05/10/19, reflected that the resident had a diagnosis of [redacted]. Review of a Dietary Progress Note, dated 08/26/18, reflected that the resident received a Puree with Nectar Thickened Liquid diet, 240 mLs	F 656		

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of Nectar Thick water every shift, 60 mLs of [redacted] supplement at bedtime, and 120 mLs of supplement twice a day. It further indicated that the resident was on aspiration precautions at meal time and needed to be fed by staff.

Review of Dietary Progress Notes, dated 03/21/19, reflected that the resident continued on a Puree with Nectar Thickened Liquid diet, 240 mLs of Nectar Thick water every shift, 60 mLs of [redacted] supplement at bedtime and 120 mLs of supplement twice a day. It further indicated that the resident was on aspiration precautions at meal times.

Review of an OT Refortification and Updated Plan of Treatment note for a Certification Period of 08/08/18 through 10/29/18 reflected that the resident had a "Precaution" for puree with nectar thick liquids.

Review of the Interdisciplinary Care Plan, with an initiation date of 05/27/18, did not reflect evidence of a comprehensive person-centered plan of care in regards to hydration/fluid maintenance and the nutrition care plan did not reflect any documentation for potential problems, goals, or resident-centered interventions or updates.

During a phone interview with the surveyor on 06/05/19 at 11:33 AM, the Registered Dietitian (RD) stated that she did not fill out the nutrition section (K) of the MDS, did not write care plans and did not attend care plan meetings.

During an interview with the surveyor on 06/05/19 at 1:15 PM, the Regional Nurse Manager stated that there should have been a care plan for dehydration related to the Annual MDS dated

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05/27/18. She further stated she could not speak to why there had been no revisions of the care plan since May 2018 or why the Nutrition care plan was incomplete and not individualized.

4. On 05/30/19 at 10:56 AM, the surveyor observed Resident #291 in a wheelchair. Both of the residents [redacted], and both [redacted] were [redacted] The resident stated that he/she had [redacted] on the [redacted] and that the nursing staff were taking care of it.

According to the Face Sheet, Resident #291 was admitted to the facility on [redacted] with a diagnosis of a [redacted]

Review of the Admission MDS, dated [redacted] reflected that the resident had a [redacted]

Review of a New Jersey Universal Precaution Transfer Form, dated [redacted], reflected the resident was on "Isolation/Precaution" for [redacted]

Review of the Nurses Note, dated 05/25/19, reflected the resident was on contact precautions related to [redacted]

Review of the Baseline Care Plan, dated 05/15/19, and a review of the Interdisciplinary Care Plans, dated 05/23/19, did not reflect evidence of the resident's plan of care for precautions related to [redacted].

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During an interview with the surveyor on 05/31/19 at 09:22 AM, a housekeeping staff member stated that she asked the nurse what to do before she entered the room due to the sign on the door.

During an interview with the surveyor on 05/31/19 at 10:20 AM, the LPN medication nurse #2 stated that there was a sign on the door to let people know to ask what to do before entering the room. She further stated that the resident had infections in the [redacted] and she can go in without a gown and gloves if she was not giving direct care.

During an interview with the surveyor on 06/05/19 at 10:41 AM, the Social Worker was unaware that the resident had a sign on the door with instruction to see the nurse before entering and was not aware if any precautions were required.

During an interview with the surveyor on 06/05/19 at 12:36 PM, the DON stated that the precautions should have been reflected on the care plan.

During an interview with the surveyor on 06/05/19 at 1:34 PM, the ADON stated that when care was given to this resident, staff should wear a gown and gloves.

5. On 5/31/19 at 12:24 PM, the surveyor observed Resident #55 ambulating in the facility hallways.

According to the Face Sheet, Resident #55 was admitted to the facility on [redacted]. The September 2018 Physician's Order Sheet (POS) revealed diagnoses which included but were not limited to; [redacted]

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[redacted]

Review of the resident's Admission MDS, dated [redacted], revealed the [redacted] A review of the Care Area Assessment (CAA) Summary, Section V of the MDS indicated the following areas addressed were to be care planned: ADL functional/Rehabilitation, Urinary Incontinence, Falls, Pressure Ulcer and Psychotropic Drug Use.

Review of the resident's Baseline care plan, dated 09/01/18, and a Physical Therapy and Occupational therapy care plan, dated 09/03/18-12/09/18, revealed there were no additional interdisciplinary care plans for Resident #55.

Review of the Quarterly MDS's, dated [redacted] and [redacted], revealed there was no evidence of interdisciplinary comprehensive care plans or revisions.

6. On 06/04/19 at 07:53 AM, the surveyor observed Resident #53 in bed eating breakfast.

According to the Face Sheet, Resident #53 was admitted to the facility on [redacted] with diagnoses which included but not limited to; [redacted].

Review of the Resident's Admission MDS, dated

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F 656	Continued From page 22 [redacted], revealed the resident had a BIMS of [redacted]. The resident's weight was coded as [redacted]. A review of the CAA Summary triggered care areas revealed ADL functional/Rehabilitation, Urinary Incontinence, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use; however, none of these care planning decisions were addressed. Review of a subsequent Quarterly MDS, dated [redacted] revealed that revealed that the resident had a BIMS of [redacted]. The Review of the Baseline care plan, dated 11/16/18, and a Physical Therapy Care Plan, dated 11/19/18 reflected there were no additional interdisciplinary care plans for Resident #55. During an interview with the surveyor on 05/31/19 at 10:51 AM, the West Wing LPN/UM stated she did not participate the initiation or revision of care plans and stated that another staff member was assigned to care planning. During an interview with the surveyor on 05/31/19 at 11:06 AM, the Regional Nurse Manager stated the UM is responsible for reviewing and updating care plans and that she had been aware that the	F 656		

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F 656	Continued From page 23 care plans were not being updated as well as care conference not being done. The Regional Nurse Manager stated care plans should be reviewed and updated during care conference after completion of the admission MDS assessment, every quarter and as changes occur. The Regional Nurse Manager also stated the DON was responsible for oversight; however, there has been a lot of turnover in facility staff. During an interview with the surveyor on 06/05/19 at 12:12 PM, the ADON, in the presence of the DON, stated that she was a UM prior to the ADON and that no one was overseeing care plans in the facility. The DON stated care plans are developed to provide the best level of care for the resident, and to have everything in place from the entire indiscipline team. The DON stated that falls should be discussed the following day in morning meeting, care plans updated and the interventions are communicated to the staff during "fall huddle." Additionally, nursing documents for three days every shift post fall. The DON stated, "We need to come up with a better process." On 06/05/19 at 12:49 PM and 12:55 PM, the surveyor reviewed Resident #55 and #53's baseline care plan and CAAs with the Director of Nursing and the Assistant Director of Nursing. During the review, the DON and ADON confirmed that comprehensive care plans should have been implemented. NJAC 8:39-11.2(e)(f)	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		7/8/19

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F 657	Continued From page 24 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to revise comprehensive care plans. This deficient practice was identified for 3 of 19 residents (Resident #6, #44, and #80) reviewed for care planning and was evidenced by the following; 1. According to the Face Sheet, Resident #80	F 657	1. Resident #80 comprehensive care plan was updated to reflect each fall as well as interventions pertaining to each fall. Resident #6 comprehensive care plan was updated to reflect each fall as well as interventions pertaining to each fall. Resident #44 comprehensive care plan was updated to reflect [redacted]	

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F 657	Continued From page 25 was originally admitted to the facility on [redacted]. Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted]. Further review of the MDS revealed that the resident required assistance with activities of daily living and had a fall with an injury. Review of Resident #80's Care Plan revealed that the resident was at risk for falls related to history of falls, poor safety awareness and impulsivity. The goal was to reduce the risk of falls and injury, and implement strategies to increase safety and prevent falls. Interventions included, but were not limited to; Bed alarm when in bed, toilet every two hours, keep call bell within reach, and tab alarm to bed and wheelchair. This care plan was created on 11/27/17, with revisions on 12/09/17 and 07/09/18, and evaluated on 11/27/17, 03/07/18 and 06/03/18. Review of the resident's Fall Risk Assessment Score, dated 03/14/18, revealed a fall risk score of 17 which indicated that the resident was a high risk for falls. Review of further fall risk assessments revealed: 07/09/18 fall risk score 11, 11/12/18 fall risk score 11, 03/04/19 fall risk score 12, and 04/14/19 fall risk score 12. The Fall Risk Assessment revealed that a score of 10 or above indicated that the resident was a high risk for falls. Review of a facility incident report, dated 07/08/18 for Resident #80, revealed that at 5:30 PM, the resident was in the dining room and was	F 657	2. All residents have the potential to be affected by the deficient practice of failing to ensure comprehensive care plans are revised. Comprehensive care plans will be reviewed and updated during the following business day clinical morning meeting for each episodic event quarterly during interdisciplinary meetings by the Unit Manager to ensure that episodic events have been captured on the care plan. 3. All clinical managerial nurses were in-serviced regarding revising comprehensive care plans and how it relates to planning and managing resident care as evidenced by documentation from admission through discharge. 4. The DON or designee will monitor five comprehensive care plans monthly for five months to ensure updates and revisions and to ensure facility policy and procedures are being followed. Findings will be reported at the next quarterly QA meeting.	

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observed sitting on her/his buttocks in front of the wheelchair. Review of a staff member statement revealed that the resident slid out of the wheelchair while trying to sit in another chair.

Review of the nurse's note, dated 07/09/18 at 6:00 PM, revealed that the nurse was notified of the resident sitting on his/her buttocks in front of a wheelchair in the dining room. The resident was medicated for complaints of back pain, and the physician was notified.

Review of a facility incident report, dated 11/12/18, revealed that at 4:30 PM, the resident was observed laying on the hall way floor. The resident sustained a [redacted]. Review of the attached facility Fall Investigation revealed that a "Personal Alarm Monitoring Device Chair" was checked off as n/a (not applicable).

Review of a nurse's note, dated 11/12/18 timed at 8:00 PM, revealed that the resident was observed laying on the [redacted] on the hallway floor. A [redacted] noted, physician was notified and neuro checks were in place.

Review of a nurse's note, dated 11/13/18 timed at 06:00 AM, revealed that the resident was status post fall day 2 of 3, with neuro checks.

Review of a nurse's note, dated 0[redacted] timed at 9:00 PM, revealed that while at another facility (current facility was evacuated), the resident fell out of bed and [redacted] to the [redacted]. The resident was sent to the emergency room and then returned on [redacted]

Further review of the nurses's notes revealed that

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the resident returned to this current facility on [redacted] and then was hospitalized on [redacted] through [redacted]

There was no evidence of revision of Resident #80's fall care plan after each fall. Additionally, there was no documentation of a post fall discussion with interventions in place.

During an interview with the surveyor on 06/04/19 at 08:25 AM, a Licensed Practical Nurse (LPN) stated she works at the facility "as needed," and that Resident #80 was a fall risk, and "everyone" was aware. The LPN stated the resident does not have alarms, and that the resident is kept in view by staff and attends activities.

During an interview with the surveyor on 06/05/19 at 10:12 AM, the [redacted] Wing LPN Unit Manager (UM) stated that she didn't know if the resident was at risk for falls, and has not had any falls since she has been the UM. The UM stated that after a resident falls, the fall is discussed in morning meeting, the care plan is updated, and nursing documents post fall for five days. Additionally, a "fall huddle" is held with the nurses and Certified Nurse Aides (CNA) to report to the staff what new interventions were in place.

During an interview with the surveyor on 06/05/19 at 12:12 PM, the Assistant Director of Nursing (ADON) in the presence of the Director of Nursing, stated she was a UM prior to an ADON, and stated that no one was overseeing care plans in the facility. The ADON stated that the care plan should have been updated with new intervention(s) after every fall. The DON stated care plans are developed to take the best care of the resident, and to have everything in place from

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the entire Interdisciplinary Team (IDT) to provide the best level of care. The DON stated that falls should be discussed the following day in morning meeting, care plans updated and the interventions are communicated to the staff during "fall huddle." Additionally, nursing documents for three days every shift post fall. The DON stated, "We need to come up with a better process."

During an interview with the surveyor on 06/06/19 at 09:01 AM, a CNA stated that the resident is a fall risk, and when the resident is awake, she brings the resident to activities. The CNA stated that the resident used to have alarms on the bed and wheelchair and a fall mat by the bed, but was not in place after the resident returned from the hospital.

On 06/06/19 at 09:48 AM, the surveyor reviewed the resident's fall care plan with the UM. The UM stated that the interventions were not accurate, and that the resident did not have any alarms in place. Additionally, the UM stated she wasn't sure if the resident had any fall interventions.

During an interview with the surveyor on 06/06/19 at 10:04 AM, the RNM stated that there is no documentation for falls post fall because it is discussed in morning meeting and fall huddle. The RNM stated the care plan should have been updated after each fall.

During an interview with the surveyor on 06/06/19 at 12:31 PM, the DON stated that there were discussions after each fall, but the care plan was not updated and should have been.

2. On 05/29/19 at 10:49 AM, the surveyor

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observed Resident #6 in a wheelchair. The surveyor attempted to interview the resident; however, he/she was unable to answer questions.

According to the Face Sheet, Resident #6 was admitted on [redacted] with diagnoses which included [redacted]

Review of the Quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted]

Review of the Physician's Order Form for June 2019, reflected an order for [redacted] given twice a day for [redacted] since 03/12/18. It further reflected diagnoses of [redacted] Type and Closed Head Injury Status Post Fall.

Review of an Incident/Accident Report, dated 05/29/18, reflected an unwitnessed fall in the residents room whereby the resident sustained a [redacted] was done which reflected [redacted]. The report further reflected that the resident stated that he/she was going to the bathroom and lost balance. Interventions included to toilet the resident every two hours and frequently remind the resident to use the call bell and frequently orient the resident. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 11/13/18, reflected an unwitnessed fall in the shower room. There was no documentation of injury. The report documents further reflected that

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the resident stated that he/she was trying to remove pants and lost balance. Interventions included to remind the resident to use the call bell. However, the report also reflected that the call bell was not within the resident's reach and was not working. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee".

Review of an Incident/Accident Report, dated 12/14/18, reflected an unwitnessed fall in the residents room whereby the resident complained of [redacted] was done which reflected [redacted]. Interventions included education to the resident on use of the call bell. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 03/13/19, reflected a witnessed fall in the residents room. There was no documentation of injury. Interventions included to remind the resident how to properly transfer and use of the call bell. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 03/17/19, reflected a witnessed fall in the resident's room. There was no documentation of injury. Interventions included to encourage the resident to use the call bell and the wheelchair when he/she needed to use the bathroom. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated

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03/30/19, reflected a fall in the dining room. There was no documentation of injury. Interventions included to remind the resident how to properly use the wheelchair. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 04/10/19, reflected a witnessed fall in the residents room. There was no documentation of injury. The statement reflected the resident tried to get into the wheelchair from the bed and became tangled in the sheets. Interventions included to educate the resident on call bell use and to avoid getting tangled in the sheets. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 05/14/19, reflected an unwitnessed fall in the residents room. There was no documentation of injury, however, the resident [redacted] was ordered which reflected [redacted]. Interventions included to remind the resident to use the call bell for assistance, to keep the wheelchair closer to the bed and to remind the resident to lock the wheelchair. The report further included a Fall Huddle sign-in sheet that reflected measures taken to prevent falls; such as, encourage the resident to use call light when resident needed to transfer from the bed to the wheelchair, to remind the resident to lock the wheelchair and to keep the wheelchair close to the bed. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of the nurse's notes, dated 05/29/18

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through 06/04/19, reflected no documentation of the resident's fall on 12/14/18. A note dated 03/14/19 reflected, "Resident continues to try and ambulate without wheelchair."

A note dated 03/31/19 reflected, "Received resident walking around room without assistance." It further reflected that the nurse explained to the resident to use the call light and wheelchair to get around. A note dated 04/11/19 reflected, "educated on using call light." A note dated 04/12/19 reflected, "reminded to use call bell for assistance."

A review of the residents Plan of Care for Risk for Falls/Injuries, initiated 11/16/17,with a goal to minimize potential for falls or fall related injury through next review, did not reflect the residents falls on 11/13/18, 12/14/18, 03/13/19, 03/17/19, and 03/30/19. The document reflected an entry on 04/26/19 related to a fall that occurred on 04/10/19. The document reflected an intervention of toileting the resident every two hours on 02/02/18 and there was no evidence of any additional or changes of interventions.

During an interview with the surveyor on 06/05/19 at 01:34 PM, the RNM stated that the resident experienced falls transferring and that she believed the resident was screened by therapy. She further stated that therapy should have been notified after falls, that each episode should have been documented in the nurses notes, and that interventions should have been updated on the care plan every time a fall occurred and when there was a new intervention.

3. On 05/30/19 at 10:49 AM, the surveyor observed Resident #44 in a high back wheelchair

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F 657	Continued From page 33 at lunch being fed by nursing staff. The resident had a gray splint on the right hand with fingers pulled tight towards the palm of the hand. According to the Face Sheet Resident #44 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. Review of an Annual Minimum Data Set (MDS), an assessment tool, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) which reflected a [redacted]. Review of the June 2019 Physician's Order Form, reflected the following orders: 03/07/19; [redacted] for five hours daily 03/07/19; [redacted] for five hours daily 05/09/19; check skin integrity of [redacted] while [redacted] is in place 05/09/19; check skin integrity of [redacted] while [redacted] is in place 05/09/19; monitor for signs and symptoms of pain while [redacted] are in place A review of a Physician's Order, dated 05/13/19, reflected to discontinue the [redacted] for five hours daily related to the resident's refusal. A review of nurse's notes from 04/10/19 through 05/13/19, reflected the refusal of the [redacted],	F 657		

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F 657	Continued From page 34 the [redacted], or both as follows: Refusal of the [redacted] dated: 05/06/19, 05/07/19, 05/08/19, 05/09/19, 05/10/19, 05/11/19, and 05/12/19. Refusal of the [redacted] dated: 04/10/19, 04/11/19, 04/13/19, 04/14/19, 04/18/19, 04/27/19, and 04/30/19. Refusal of both [redacted] dated: 03/29/19, 04/01/19, 04/02/19, 04/05/19, 05/04/19, and 05/05/19. A review of the Occupational Therapy care plan dated 06/05/18, reflected [redacted] of the [redacted] for four hours twice a day related to [redacted] and [redacted]. There was no evidence of revision or update of this care plan to reflect the above. During an interview with the surveyor on 06/05/19 at 10:11 AM, the Director of Therapy stated that therapy initiated care plans once a resident was discharged from therapy and after that nursing updated the care plans. During an interview with the surveyor on 06/05/19 at 1:15 PM, the RNM stated that nursing was in charge of updating [redacted] plans and that she could not explain why there were no revisions reflected on the care plan. Review of a facility policy titled, "Resident Care Plan Policy and Procedure" dated reviewed 5/27/19, included, The care plan is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. The care plan will identify	F 657		

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F 657	Continued From page 35 priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There will be ongoing documentation of the nursing process related to resident needs from admission to discharge. The following health care professionals contribute to the Interdisciplinary Care Plan by collaboration and direct documentation: RN, LPN, CNA, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist, Activity Director, Social Worker (SW), Dietitian, Physician and other appropriate members of the Care Plan Team. Care Plans are modified between care plan conference when appropriate to meet the resident's current needs, problems and goals. The care plan will be updated and/or revised for the following reasons: significant change in the resident's condition; a change in planned interventions; goals are obtained and new goals established to meet current resident needs and/or goals and new diagnosis, new medications, etc. NJAC 8:39-11.1, 11.2	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to	F 658	1. Nurses were identified for not initialing Resident #62 Medication Administration	7/8/19

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F 658	Continued From page 36 a.) document that physician ordered medications were administered and to document the omissions for 1 of 1 residents reviewed for medication documentation (Resident #62), and b.) ensure a resident's Physician Orders reflected contact precautions for 1 of 2 residents (Resident #291). This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the Face Sheet, Resident #62	F 658	Record on 4/4/19, 4/8/2019, 4/17/2019 and 4/22/2019. A Physician Order was written to reflect isolation precautions related to Resident #291 infection. 2. All residents have the potential to be affected by this deficient practice of failing to document that physician ordered medications were administered and to document omissions. All residents have the potential to be affected by the deficient practice of failing to ensure physician orders reflect infection isolation precautions. 3. Nurses identified with omissions and all nurses were in-serviced regarding medication administration protocol. All nurses were in-serviced regarding writing appropriate physician orders as it relates to precautions needed to manage resident care. All staff were in-serviced on isolation precaution measures and definitions related to isolation precaution. 4. The DON or designee will monitor each MAR on a weekly basis for three months to ensure that all medications have been appropriately signed. The DON or designee will review weekly residents records admitted from the hospital to determine if isolation precaution is required and that a physician order has been written in the chart if required. Findings will be reported at the next quarterly QA meeting.	

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F 658	Continued From page 37 was admitting to the facility on [redacted] with diagnoses that included the following: [redacted] Review of Resident #62's Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview for Mental Status ([redacted] Review of Resident #62's Care Plan, dated 11/15/18 and on-going, revealed the following care areas: Psychotropic drug use for [redacted] with interventions that included: administer medications per doctor's orders; [redacted] with interventions that included: [redacted] Review of Resident #62's Physician Orders revealed the following: [redacted]. Review of Resident #62's April 2019 Medication Administration Record (MAR) revealed the following medications were not initialed as administered: [redacted]	F 658		

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[redacted]

The April 2019 MAR also revealed, on 4/4/19 and 4/8/19, nurse initials crossed out with a hand drawn square symbol underneath. The square was empty.

Review of Resident #62's Nurse's Notes revealed no March 2019 or April 2019 documentation with regard to all of the above medications.

During an interview with the surveyor on 06/03/19 at 09:30 AM, the East Wing unit's Licensed Practical Nurse (LPN) Unit Manager (UM) stated that she did not know what the square symbol was under the crossed out initials on the April 2019 MAR. She stated that it was not a facility code and should not have been used. She also stated that medications should all be administered as ordered unless there was an issue, but then there should always be a note on the back of the MAR and a Nurse's Note written.

The LPN/UM also stated that it was the responsibility of the UM to look over the MAR, but that she was not aware of the time frame for that to be done.

During an interview with the surveyor on 06/03/19 at 11:08 AM, the [redacted] unit LPN stated that when she holds a medication for whatever reason, she would have initialed and circled the MAR and then would write on the back of the MAR the reason the medication was held and then would write a Nurse's Note. During the interview, the surveyor showed the LPN the square symbol on

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Resident #62's April 2019 MAR. She stated that was not a symbol used at the facility.

During an interview with the surveyor on 06/03/19 at 12:18 PM, the [redacted] LPN stated that when she held a medication, she would initial and circle the MAR, write a note on the back of the MAR, write a Nurse's Note, and call the physician.

During an interview wit the surveyor on 06/03/19 at 1:10 PM, the Director of Nursing (DON) stated that if there was an issue, such as if the resident refused, the nurse should initial and circle the MAR and then document on the back of the MAR and the Nurse's Notes. She also stated that the nurses should be documenting the medication was given as soon as the medications were administered.

Review of the "Medication Administration Policy and Procedure", dated 01/13/19, revealed that if a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose and must indicate the reason the medication was withheld, refused or administered on the back of the MAR. In addition, the policy revealed that the nurse administering the medication must initial the resident's MAR on the appropriate line after giving each medication.

2. On 05/30/19 at 10:56 AM, the surveyor observed Resident #291 seated in a wheelchair with the resident's [redacted]. The resident's [redacted], and [redacted]. The resident stated that he/she had [redacted] on the f[redacted] and that the nursing staff were taking

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F 658	Continued From page 40 care of it. According to the facility, Resident #291 was admitted on [redacted] with diagnoses that included a [redacted]). Review of the Admission MDS, dated [redacted], reflected that the resident had a BIMS of [redacted] Review of a New Jersey Universal Precaution Transfer Form, dated [redacted], reflected the resident was on "Isolation/Precaution" for [redacted]. Review of the Physician's Orders (PO), dated 05/15/19, did not reflect evidence of a PO for contact precautions. Review of the PO, dated 06/05/19, reflected the following: "late entry: pt on isolation precautions/contact precautions re: [redacted] Review of the Nurse's Note, dated 05/25/19, reflected the resident was on contact precautions related to [redacted] During an interview with the surveyor on 05/31/19 at 09:22 AM, a Housekeeping staff member stated that she asked the nurse what to do before she entered the room due to the sign on the door. During an interview with the surveyor on 05/31/19 at 10:20 AM, the Licensed Practical Nurse/Medication Nurse (LPN/MN) stated that	F 658		

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F 658	Continued From page 41 there was a sign on the door to let people know to ask what to do before entering the room. She further stated that the resident had infections in the [redacted] and she can go in without a gown and gloves if she was not giving direct care. During an interview with the surveyor on 06/05/19 at 10:41 AM, the Social Worker was unaware that the resident had a sign on the door with instruction to see the nurse before entering and was not aware if any precautions were required. During an interview with the surveyor on 06/05/19 at 12:36 PM, the Director or Nursing (DON) stated that documentation of precautions should have been in the chart on the physician's orders. NJAC: 8:39-19.1, 19.1(b), 29.2(a)(d), 29.3(5)	F 658		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, review of medical records and other facility documentation, it was determined that the facility failed to comprehensively investigate and implement individualized interventions to ensure resident safety.	F 689	1. Resident #6 incident reports were reviewed and the comprehensive care plan was updated to reflect incidents and interventions initiated at the time of incident. Resident #80 incident reports were reviewed and the comprehensive care plan was updated to reflect incidents	7/8/19

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F 689	Continued From page 42 This deficient practice was identified for 2 of 2 residents reviewed for falls (Resident #6 and #80) and was evidenced by the following: 1. On 05/29/19 at 10:49 AM, the surveyor observed Resident #6 seated in a wheelchair. The surveyor attempted to interview the resident; however, he/she was unable to answer questions. On 06/06/19 at 08:43 AM, the surveyor observed the resident laying in bed, the resident's room was the second to the last room down the hallway from the nurses' station. According to Face Sheet (an admission summary), Resident #6 was admitted to the facility on [redacted] with diagnoses which included [redacted]. Review of the Annual Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted]. Review of the Quarterly MDS, dated [redacted] reflected that the resident had a BIMS of [redacted] Review of the June 2019 Physician's Order Form, reflected the medication [redacted] to be given twice a day for [redacted] since 03/12/18. It further reflected diagnoses of [redacted] Type and Closed Head Injury Status Post Fall. Review of a Medical Progress Note, dated 06/22/18, reflected the resident had a fall on 05/29/18 and had a [redacted] It further reflected diagnoses of	F 689	and interventions initiated at the time of incident. 2. All residents have the potential to be affected by this deficient practice of failing to comprehensively investigate and implement individualized interventions to ensure resident safety. 3. All nurses were in-serviced on the facility's Resident Incident and Accident Policy and Procedure, the revised incident and accident report forms as well as the interdisciplinary forms to be signed to communicate incidents that occur in the facility. All clinical managerial staff were in-serviced regarding updating comprehensive care plans and how it relates to planning and managing resident care and the importance of including interventions that apply specifically to the resident and the circumstances involving the incident. 4. The DON or designee will review and track all incident reports from the previous month for four months to ensure that each incident report has been investigated for accuracy and completion. The DON or designee will monitor five comprehensive care plans monthly for five months to ensure updates and revisions for each incident. Findings will be reported at the next QA meeting.	

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[redacted]

Review of a Medical Progress Notes, dated 08/30/18, 09/30/18 and 10/02/18, reflected diagnoses of [redacted]

Review of a Nurse Practitioner's Note, dated 05/17/19, reflected the resident had a history of falls and an assessment/plan which stated abnormality of gait, fall precautions and wheelchair use.

Review of the resident's Fall Risk Evaluations, dated 05/29/18, 08/06/18,11/06/18, 02/06/19, and 05/06/19 reflected that the resident had a total fall risk score of 14 which reflected a high risk for falls, and a score of two for Level of Consciousness/Mental Status which reflected the resident was disoriented at all times.

Review of an Incident/Accident Report, dated 05/29/18, reflected an unwitnessed fall in the resident's room whereby the resident sustained a [redacted] and complained of [redacted] was done which reflected [redacted]. The report further reflected that the resident stated that he/she was going to the bathroom and lost balance. Interventions included to toilet the resident every two hours, frequently remind the resident to use the call bell, and frequently orient the resident. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 11/13/18, reflected an unwitnessed fall in the shower room. There was no documentation of

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F 689	Continued From page 44 injury. The report documents further reflected that the resident stated that he/she was trying to remove pants and lost balance. Interventions included to remind the resident to use the call bell. However, the report also reflected that the call bell was not within the resident's reach and was not working. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee." Review of an Incident/Accident Report, dated 12/14/18, reflected an unwitnessed fall in the resident's room whereby the resident complained of [redacted]. [redacted] Interventions included education to the resident on use of the call bell. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee." Review of an Incident/Accident Report, dated 03/13/19, reflected a witnessed fall in the resident's room. There was no documentation of injury. Interventions included to remind the resident how to properly transfer and use of the call bell. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee." Review of an Incident/Accident Report, dated 03/17/19, reflected a witnessed fall in the resident's room. There was no documentation of injury. Interventions included to encourage the resident to use the call bell and the wheelchair when he/she needed to use the bathroom. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."	F 689		

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Review of an Incident/Accident Report, dated 03/30/19, reflected a fall in the dining room. There was no documentation of injury. Interventions included to remind the resident how to properly use the wheelchair. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 04/10/19, reflected a witnessed fall in the resident's room. There was no documentation of injury. The statement reflected the resident tried to get into the wheelchair from the bed and became tangled in the sheets. Interventions included to educate the resident on call bell use and to avoid getting tangled in the sheets. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

Review of an Incident/Accident Report, dated 05/14/19, reflected an unwitnessed fall in the resident's room. There was no documentation of injury; however, the resident [redacted] was ordered which reflected [redacted]. Interventions included to remind the resident to use the call bell for assistance, to keep the wheelchair closer to the bed and to remind the resident to lock the wheelchair. The report further included a Fall Huddle sign in sheet that reflected measures taken to prevent falls. The measures included: encourage the resident to use call light when resident needed to transfer from the bed to the wheelchair, to remind the resident to lock the wheelchair and to keep the wheelchair close to the bed. The Fall Investigation form indicated that "all investigations will be reviewed by the Interdisciplinary Fall/Incident Committee."

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F 689	Continued From page 46 Review of the nurse's notes dated, 05/29/18 through 6/04/19, reflected no documentation of the resident's fall on 12/14/18. A note dated 03/14/19 reflected, [redacted] Review of a nurse's note, dated 03/31/19 reflected, "Received resident walking around room without assistance." The note further reflected that the [redacted] A note, dated 04/11/19 reflected, "educated on using call light." A note dated 04/12/19 reflected, "reminded to use call bell for assistance." Review of the Social Service Progress Note (quarterly care conference), dated 08/16/18, reflected a meeting was held with the residents [redacted] (the resident refused to attend). The documentation reflected the resident had three falls that quarter and was a fall risk. It further reflected that falls occurred while the resident attempted to get out of bed without assistance. It also reflected that staff remind the resident to wait for help and that the family was aware that the resident was forgetful and needed constant reminders. In addition, the resident's family member inquired if the resident could benefit from a walker and the Social Worker documented that he/she would inform therapy. Review of the resident's Plan of Care for Risk for Falls/Injuries, initiated 11/16/17 with a goal to minimize potential for falls or fall related injury through next review, did not reflect the residents falls on 11/13/18, 12/14/18, 03/13/19, 03/17/19, and 03/30/19. The document reflected an entry on 04/26/19 related to a fall that occurred on	F 689		

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04/10/19. The document reflected an intervention of toileting the resident every two hours on 02/02/18 and there was no evidence of any additional or changes of interventions. The document also reflected an entry on 11/16/18 that Social Service would consult Physical Therapy for possible usage of a walker. This was referenced in a Social Service Progress Note (quarterly care conference), dated 08/16/18, and there was no documented evidence that this occurred.

During an interview with the surveyor on 06/05/19 at 10:02 AM, the Director of Therapy stated that if a resident experienced a fall she would be notified in the facility's morning meeting and she was given a copy of the incident report. The department would then screen the resident to assess the need for skilled services. She further stated that there are no "fall meetings." However, falls are discussed in clinical meetings with the nurse. She stated the screen forms should have been in the chart. The Director of Therapy also stated that this resident was referred to her yesterday because the resident had multiple falls. She further stated that the resident had falls during self transfers, he/she is not safe for self transfers and the resident was educated. She stated she thinks the resident can recall education. The Director of Therapy was unable to provide documented evidence of screening the resident after falls.

During an interview with the surveyor on 06/05/19 at 10:25 AM, the Certified Nurses Aide (CNA) stated the resident usually falls in his/her room during transfers. She stated the interventions for fall prevention were to keep the resident busy and visible.

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During an interview with the surveyor on 06/05/19 at 10:53 AM, the Licensed Practical Nurse (LPN) stated that she thinks the resident fell recently and was unaware of anything special to for the resident to prevent falls.

During an interview with the surveyor on 6/05/19 at 1:34 PM, the Regional Nurse Manager stated that the resident experienced falls transferring and that she believed the resident was screened by therapy. She further stated that therapy should have been notified after falls, that each episode should have been documented in the nurses notes, and that interventions should have been updated on the care plan every time a fall occurred and when there is a new intervention.

During an interview with the surveyor on 06/06/19 at 09:29 AM, the LPN Unit Manager (LPN/UM) stated that after a resident experienced a fall there is a "fall huddle" with the nurses and CNA's to discuss what happened and why it occurred. She stated the resident thinks he/she is independent and that the resident is reminded to use the call light and wheelchair. She stated that the falls are discussed in morning meeting, therapy is notified and the resident would get evaluated. In addition, she stated that the residents family member and physician were notified and there were no new orders. She could not state whether there had been any meetings in regards to the resident's falls.

During an interview with the surveyor on 06/06/19 at 09:55 AM, the LPN/UM stated that there were no other interventions in place for fall prevention other than to remind the resident to use the call bell and wait for help. In regards to the resident's cognition, the LPN/UM could not state whether an

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F 689	Continued From page 49 intervention of education would be appropriate and effective. During an interview with the surveyor on 06/06/19 at 10:32 AM, the LPN/UM stated that accountability for the "fall huddle" was a part of the Incident Report and that the "fall huddle" process was started three weeks ago. During an interview with the surveyor on 06/06/19 at 12:54 PM, the Director of Nursing (DON) reviewed the residents Fall Risk Evaluations and the residents quarterly MDS dated [redacted] which reflected a BIMS of [redacted]. 2. On 06/03/2019 at 11:20 AM, the surveyor observed Resident #80 lying in bed. According to the Face Sheet, Resident #80 was originally admitted to the facility on [redacted] with diagnoses including but not limited to; [redacted]. Review of the resident's Quarterly MDS, dated [redacted], revealed that the [redacted] which indicated that the [redacted]. The MDS also revealed that the resident required assistance with activities of daily living and had a fall with an injury. Review of Resident #80's Care Plan revealed that the resident was at risk for falls related to history of falls, poor safety awareness and impulsivity. The goal was to reduce the risk of falls and injury, and implement strategies to increase safety and prevent falls. Interventions included but were not limited to; Bed alarm when in bed, toilet every two	F 689		

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hours, keep call bell with in reach, tab alarm to bed and wheelchair. This care plan was created on 11/27/17, with revisions on 120/9/17 and 07/09/18, and was evaluated on 11/27/17, 03/07/18, and 06/03/18.

Review of the resident's Fall Risk Assessment Score, dated 03/14/18, revealed a fall risk score of 17 which indicated that the resident was a high risk for falls. Review of further fall risk assessments revealed:
07/09/18: a total fall risk score of 11;
11/12/18: a total fall risk score of 11;
03/04/19: a total fall risk score of 12;
04/14/19: a total fall risk score of 12.
The Fall Risk Assessment revealed that a score of 10 or above indicated that the resident was a high risk for falls.

Review of a facility incident report, dated 07/08/18, revealed that at 5:30 PM the resident was in the dining room and was observed sitting on her/his buttocks in front of the wheelchair. Review of staff member statement revealed that the resident slid out of the chair trying to sit in another chair.

Review of the nurse's note, dated 07/09/18 at 6:00 PM, revealed that the nurse was notified of the resident sitting on his/her buttocks in front of a wheelchair in the dining room. The resident was medicated for complaints of back pain, and the physician was notified.

The facility was unable to provide any follow up nurse's notes post fall and there was no revision of the resident's care plan.

Review of a facility incident report, dated

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F 689	Continued From page 51 11/12/18, revealed that at 4:30 PM, the resident was observed laying on the hall-way floor. The resident sustained a [redacted]. A review of the attached facility Fall Investigation revealed that a "Personal Alarm Monitoring Device Chair" was checked off as n/a (not applicable). Review of a nurses note, dated 11/12/18, timed at 8:00 PM, revealed that the resident was observed laying on the [redacted] on the hallway floor. [redacted] physician was notified and neuro checks were in place. Review of a nurse's note, dated 11/13/18, timed at 06:00 AM, revealed that the resident was status post fall day 2 of 3, with neuro checks. There were no further nurse's notes addressing the fall and there was no revision of the resident's care plan. Review of a nurse's note, dated [redacted] timed at 9:00 PM, revealed that while at another facility (current facility was evacuated), the resident fell out of bed and sustained a [redacted] The resident was sent to the emergency room and then returned on [redacted] Review of the nurses's notes revealed that the resident returned to this current facility on [redacted] and then was hospitalized on [redacted] through [redacted] There was no evidence of revision of the fall care plan. Additionally, there was no documentation of a post fall discussion with interventions in place. During an interview with the surveyor on 06/04/19	F 689		

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at 08:25 AM, a LPN stated she works at the facility "as needed", and stated that Resident #80 was a fall risk, and "everyone" was aware. The LPN stated the resident does not have alarms, and that the resident is kept in view by staff and attends activities.

During an interview with the surveyor on 06/05/19 at 10:12 AM, the [redacted] LPN/UM stated that she didn't know if the resident was at risk for falls, and has not had any falls since she has been UM. The UM stated that after a resident falls, it is discussed in morning meeting, the care plan is updated, and nursing documents post fall for five days. Additionally, a "fall huddle" is held with the nurses and CNAs to report to the staff what new interventions are in place.

During an interview with the surveyor on 06/05/19 at 12:12 PM, the Assistant Director of Nursing (ADON), in the presence of the DON, stated that she was a UM prior to becoming the ADON, and stated that no one was overseeing care plans in the facility. The ADON stated that the care plan should have been updated with new intervention(s) after every fall. The DON stated care plans are developed to provide the best level of care for the resident, and to have everything in place from the entire interdiciplinary team. The DON stated that falls should be discussed the following day in morning meeting, care plans updated and the interventions are communicated to the staff during "fall huddle." Additionally, nursing documents for 3 days every shift post fall. The DON stated, "We need to come up with a better process."

During an interview with the surveyor on 06/06/19 at 09:01 AM, a CNA stated that the resident is a

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F 689	Continued From page 53 fall risk, and when the resident is awake, she brings the resident to activities. The CNA stated that the resident used to have the bed and chair alarms and a fall mat by the bed, but was not in place after the resident returned from the hospital. On 06/06/19 at 09:48 AM, the surveyor reviewed the resident's fall care plan with the UM. The UM stated that the interventions were not accurate and that the resident did not have any alarms in place. Additionally, the UM stated she wasn't sure if the resident had any fall interventions. During an interview with the surveyor on 06/06/19 at 10:04 AM, the Regional Nurse Manager (RMN) stated that there is no documentation for falls post fall because it is discussed in morning meeting and fall huddle. The RNM stated the care plan should have been updated after each fall. During an interview with the surveyor on 06/06/19 at 12:31 PM, the DON stated that there were discussions after each fall, but the care plan was not updated and should have been. NJAC 8:39-27.1(a)	F 689		
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-	F 692		7/8/19

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F 692	Continued From page 54 §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: Based on observation, interview and record review, it was determined that the facility failed to ensure that person-centered care plans were in place to address and monitor unplanned weight loss for 2 of 5 residents (Resident #53 and #57) reviewed for nutrition. This deficient practice was evidenced by the following: 1. On 05/30/19 at 09:20 AM, the surveyor observed Resident #53 in bed. The resident was awake, appeared thin and had [redacted]. At that time, the resident stated that he/she had weight loss. According to the face sheet, Resident #53 was admitted to the facility on [redacted] with diagnoses which included but not limited to; [redacted]). Review of an Advanced Practice Nurse (APN) Progress Notes, dated 11/29/18, 12/06/18 and	F 692	1. Resident #53 comprehensive care plan was updated to reflect nutritional status and weight fluctuation from date of admission. Resident #57 comprehensive care plan was updated to reflect weight loss experienced since June 2018. 2. All residents have the potential to be affected by this deficient practice of failing to ensure that person-centered care plans are in place to monitor unplanned weight loss. 3. All nurses were in-serviced on the facility's Weight Program Policy and Procedure with reiteration of proper documentation of weights obtained. All clinical managerial staff was in-serviced regarding updating comprehensive care plans and how it relates to planning and managing resident care and the importance of including interventions that apply specifically to resident weight loss and fluctuation. The Consultant Dietician	

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F 692	Continued From page 55 12/13/18, revealed that the resident had a past medical history of [redacted]. The Progress Notes also revealed that the resident was [redacted]. Review of the resident's admission Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) of [redacted] Review of a subsequent quarterly MDS, dated [redacted], revealed that the resident had a BIMS of [redacted]. Review of the resident's medical record revealed a base-line Care Plan, dated 11/16/18, and a Physical Therapy Care Plan, dated 11/19/18. The base-line Care Plan did not address the resident's nutritional status or weight. There were no additional interdisciplinary care plans for Resident #55. Review of the resident's "Monthly Vital Signs/Weights" sheet revealed the following weights: November 2018: [redacted] December 2018: [redacted] January 2019: [redacted] February 2019: [redacted]	F 692	Contract was reviewed with the facility Registered Dietician and reiteration of assessment, documentation, planning and implementation of nutritional care as well as submitting monthly summary reports of services provided. 4. The DON or designee will review and track all monthly weights monthly obtained with specific emphasis on weight loss and fluctuations weekly. The DON or designee will monitor that weights are appropriately documented per policy in the charts of residents identified with weight loss or fluctuation. The DON or designee will communicate weight loss and fluctuation to the dietician and review weekly dietician progress notes ensuring weight concerns are documented. Findings will be reported at the next QA meeting.	

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F 692	Continued From page 56 March 2019: [redacted] April 2019: [redacted] May 2019: [redacted] Review of the resident's Medical Nutrition Assessment, dated 11/23/18, revealed that the resident's weight was [redacted], with a usual body weight (UBW) of [redacted]. The nutritional summary revealed that the resident's intake was observed during meal time and that the resident was meeting nutritional needs. Additionally, the summary revealed that the resident had [redacted]. Recommendations were a regular chopped diet. Review of a Nurse's Note, completed by the Assistant Director of Nursing (ADON) dated, 04/12/19, revealed that the resident's weight decreased [redacted] in one month (March-April) and that the resident was placed on weekly weights, meal monitoring for 7 days, and a dietician consult. Additionally, the note read, "Although this was an unplanned weight loss, current weight is UBW..." There were no other prior nurses notes that addressed the resident's weight. Review of the Dietary Progress Notes revealed a note, dated 04/19/19, that was titled as a weight loss consult. The Dietary Progress Note revealed that the dietician spoke with the resident who reported good intake with enough to eat and that the resident was agreeable to a supplement related to recent weight loss. The progress note weights addressed were January 2019 through April 2019 which was documented as a 6% weight loss over 3 months. Review of a Physician's Order, dated 04/22/19,	F 692		

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revealed an order for [redacted] 120 milliliter (ml) twice daily for weight loss.

There was no documentation in the medical record addressing the weight change from November 2018 to December 2018 or weekly weights mentioned in the 04/12/19 Nurse's Note. There was no documentation in the Dietary Progress Notes that reflected the resident's significant weight loss from March 2019-April 2019. Additionally, there were no interventions or a care plan in place addressing the resident's weight loss.

On 06/05/19 at 08:09 AM, the surveyor observed a Certified Nurses Aide (CNA) assisting the resident with breakfast. The resident ate approximately 50% of the meal and told the CNA that he/she did not want anymore to eat. The resident stated that he/she was able to feed him/herself and that staff provided assistance when needed. The surveyor attempted to continue to interview the resident; however, the resident was not answering the surveyor.

During an interview with the surveyor on 06/04/19 at 09:47 AM, the [redacted] Unit Manager (UM) stated monthly weights are taken and staff would reweigh the resident when there was a 3-5 lb difference. The dietician reviews the weights, reads the Medication Administration Record, and writes recommendations which are provided to the Director of Nursing (DON). The UM stated that Resident #53 required assistance with eating at times, and eats 100% of meals. The UM stated the resident lost a "couple of pounds" and was on a high calorie supplement.

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F 692	Continued From page 58 During a follow up interview with the surveyor on 06/05/19 at 10:12 AM, the [redacted] UM stated weight changes would be discussed at morning meeting with a plan to address it. The UM stated interventions such as ordering supplements, and blood work would be discussed and the physician, dietician and family are notified. During a telephone interview with the surveyors on 06/05/19 at 11:31 AM, the Dietician stated that she was a consultant dietician to the facility and was responsible for nutrition documentation for nutrition concerns and interventions. She stated she completed the initial, quarterly, and annual assessments and addressed weight loss based on the weight fluctuations identified in the weight report provided by the Assistant Director of Nursing (ADON) on a monthly basis. The dietician stated that she did not write care plans, attend weight meetings, care conference, or complete the MDS. When the surveyor asked about Resident #53, she stated that another dietician was responsible at that time, that it was a significant weight loss, and that a re-weigh should have been done when there was a change in the weight. During an interview with the surveyors on 06/05/19 at 12:12 PM, the ADON in the presence of the DON, stated that upon admission, weekly weights were to be done for four weeks, and recorded on the resident's weight sheet. The ADON stated weights were compared from the previous month and if there was a change of 5 lb less or more, the dietician is notified. The ADON stated that the facility does not have monthly weight meetings. During an interview with the surveyors on	F 692		

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F 692	Continued From page 59 06/05/19 at 1:04 PM, the Regional Nurse Manager, in the presence of the ADON and DON, stated that the facility believed that Resident #53's initial weight was a transcription error, and the weight should have been addressed by ensuring a re-weigh was done, and then weekly weights for four weeks. Additionally, the Regional Nurse Manager stated that Resident 53's weight loss should have been care planned. 2. On 05/29/19 at 10:42 AM, the surveyor observed Resident #57 in a wheelchair. The resident presented with [redacted] and was leaning to the left side of the wheelchair. During an interview, the resident stated that he/she had [redacted]. According the face sheet, Resident #57 was admitted to the facility on [redacted] with diagnoses which included but not limited to; [redacted] Review of the resident's quarterly MDS, dated [redacted], revealed that the resident had a BIMS of [redacted] Review of the resident's Interdisciplinary Care Plan for Nutrition/Weight, dated 06/17/18, reflected no documentation of problems, goals, person-centered interventions, as well as, no documentation of weight losses and no evidence of care plan revisions, since 06/17/18.	F 692		

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F 692	Continued From page 60 Review of the resident's "Monthly Vital Signs/Weights" sheet revealed the following weights: June 2018: [redacted] July 2018: [redacted] September 2018: [redacted] October 2018: [redacted] January 2019: [redacted] February 2019: [redacted] March 2019: [redacted] Review of the resident's Medical Progress Note, dated 06/29/18, reflected a diagnosis of mild protein-calorie malnutrition. Review of the resident's Medical Progress Note, dated 07/30/18, reflected a diagnosis of [redacted] Review of the resident's Medical Progress Note, dated 09/23/18, reflected a diagnosis of [redacted] Review of an APN Progress Note, dated 10/04/18, reflected "no significant weight change." Review of the Nurses' Notes from June 2018 through March 2019, reflected no documentation of the resident's weight losses. Review of the resident's Dietary Progress Notes reflected no evidence that the significant weight	F 692		

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losses in July 2018 and October 2018 were identified and addressed. There was no evidence that the significant weight loss in February 2019 was identified and addressed in a timely fashion. The Dietary Progress Note, dated 03/15/19, reflected the significant weight loss in February; however, it did not reflect the March weight of [redacted] and the resident's continued weight loss. The Dietary Progress Note, dated 03/15/19, reflected an intervention to increase a liquid supplement to twice a day.

Review of a Physician's Order, dated 03/16/19, revealed an order for [redacted] 120 ml twice daily for supplement.

During an interview with the surveyor on 06/04/19 at 12:15 PM, the resident stated he/she asked for him/her supplement at breakfast and likes the vanilla flavor. The resident further stated that he/she would like to have the supplement more during the day.

During an interview with the surveyor on 06/05/19 at 10:20 AM, the CNA stated that she was unaware that the resident had weight losses.

During an interview with the surveyor on 06/05/19 at 10:53 AM, the Licensed Practical Nurse stated that she was unaware that the resident had weight losses.

During a phone interview with the surveyor on 06/05/19 at 11:51 AM, the Registered Dietitian (RD) stated she could not speak about this resident because she did not have the chart in front of her to refer to.

During an interview with the surveyor on 06/05/19

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at 1:27 PM, the Regional Nurse Manager, DON and ADON acknowledged that the nutrition care plan problem and goal areas should have been completed and should have been individualized.

During an interview with the surveyor on 06/05/19 at 1:40 PM, the Regional Nurse Manager, DON and ADON acknowledged that the RD should have documented on the significant weight losses. They further acknowledged that the RD should have documented on the March weight of [redacted] in the March Dietary Progress Note.

Review of the "Consultant Dietician Contract" included but was not limited to; Consultant Responsibilities: 1. Review the resident's medical history and assess their nutritional status. Plan, document and implement nutritional care for all residents. 3. Maintain a summary of consultation activities in the facility and submit a written, monthly report of all services rendered.

During an interview with the surveyors on 06/06/19 at 2:12 PM, the Administrator stated that there were no monthly activity reports from the RD.

Review of the facility's "Weight Policy, Program and Procedure," dated reviewed 05/27/19, indicated that all residents will be weighed on admission and readmission to the facility and weekly for 4 weeks after admission to establish a baseline weight. The resident will be weighed at least monthly thereafter to monitor established goals by the IDC [Interdisciplinary Care] team. Establishing a weight baseline will assist the facility in completing a comprehensive nutritional assessment. The facility dietitian helps identify nutritional risk factors and recommends

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nutritional interventions based on each resident medical condition, needs, desires and goals. The IDC team evaluates the nutritional information from multiple sources to include, but not limited to the Resident Assessment Instrument (RAI), and additional nutritional assessment as indicated to determine a residents' nutritional status and develop an individualized care plan.
Based on information generated by the comprehensive assessment and any pertinent additional nutritional assessments, the interdisciplinary team develops an individualized care plan. The care plan is updated as needed: as condition changes. Suggested parameters for evaluating significance of unplanned or undesired weight loss are:

Interval	Significant loss	Severe loss
1 month	5%	Greater than 5%
6 months	10%	Greater than 10%

Procedure:
The Unit Manger (UM) assigns staff to weigh residents by the 5th of each month. All monthly weights are to be reviewed by the UM. Any resident's weight noted to be 5 lbs lost or gained is to be reweighed by staff with supervision. Residents confirmed with 5 lbs loss or gain will be placed on that month's weight fluctuation sheet which will be documented in the weight book and weekly weights will be initiated for 4 weeks. The UM is responsible for obtaining new orders from the facility dietician and assigned physician for residents noted on the monthly fluctuation sheet. The UM will initiate the 6 month fluctuation sheet which is intended to be reviewed 6 months prior to the current months weight. In the event a 10%

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weight loss or gain is noted the facility dietician and assigned physician will be notified to obtain new orders. The weights will be reviewed monthly by the Director of Nursing. A copy of the report will be given to the facility dietician for review, who will document on residents with significant weight losses or gains. The MD will be notified of any significant changes. Upon completion of the above review, weights are then placed in the resident's chart.

Review of a facility policy titled, The Role of the Dietitian and Nutritional Assessments, included but was not limited to; 1. On a monthly basis, the resident's weight will be recorded by the nurse in the Medical Record and on the weight fluctuation sheet. Any resident who has displayed a weigh difference of 5 pounds in one month will be noted. The nurse will notify the Dietitian of these residents by leaving a copy of the information in the Dietitian meal box. The Dietitian will complete a nutritional assessment on her next scheduled visitation date. 3. The dietitian and/or designee will complete a nutritional assessment for each resident. The assessment will be coordinated with Inter-Disciplinary Care Plan Team meeting. The food Service Director or designee will attend the IDCP conference to incorporate the stated goals into the Inter-disciplinary goals. Any conflict will be reported to the Dietitian upon her visits for a resolution.
4. A nutritional assessment will include, but not be limited to: diet order; food preferences; food allergies; height; weight; ideal weight range; assessment of current lab values; presence of decubs; appetite; feeding skills; swallowing abilities; diet counseling; change of diet; results of previous goals established; height or weight change; noted progress or lack thereof; food-drug

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F 692	Continued From page 65 interaction; additional comments; goals with specific time frames and methodology; date of birth and diagnosis. 6. The above guidelines state the minimal charting requirements. Any resident who has displayed a significant weight difference; whose medical condition is unstable; or who displayed a nutritional problem will be assessed on a more frequent basis as determined by the physician. 7. The dietitian will complete this assessment within seven days of receipt of the request. NJAC 8:39-27.2(a)	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		7/8/19

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STERLING MANOR	794 N FORKLANDING ROAD MAPLE SHADE, NJ 08052

(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 761	Continued From page 66 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of other facility documents, it was determined that the facility failed to ensure that a.) in-use [redacted] vials where dated when opened; and b.) the refrigerator locked narcotic box was permanently affixed. This deficient practice was identified for 1 of 2 medication carts and 1 of 1 medication storage room reviewed for medication storage and was evidenced by the following: 1. On 05/29/19 at 09:04 AM, the surveyor reviewed the [redacted] medication cart with the Licensed Practical Nurse (LPN) Unit Manager (UM) (LPN/UM #1) and observed the following stored inside: a.) 10 pink unidentifiable capsules in an unlabeled plastic medication cup with a paper med cup on top; b.) the following in-use [redacted] vials were not labeled with the date they were opened: a [redacted]. The vials were each stored in a separate plastic, undated medication bottle. The vials were labeled for four individual residents. During an interview at that time, the [redacted] LPN/UM #1 stated that the loose capsules should not have been in the medication cart. She also stated that the [redacted] vials should have been dated when were opened.	F 761	1. The 10 pink unidentifiable capsules in an unlabeled plastic medication cup with a paper med cup on top were immediately discarded. The vials of [redacted] that were stored separately in plastic bags undated were immediately discarded. A locked narcotic box was permanently affixed to the refrigerator in the medication room on the date identified as not properly affixed. 2. All residents have the potential to be affected by this deficient practice of failing to ensure that an in-use [redacted] vials are dated when opened and not having a locked narcotic box permanently affixed to the refrigerator. 3. All nurses were in-serviced regarding ordering medications as depletion occurs, not storing unidentifiable capsules in the medication cart and labeling drugs and biologicals used in the facility according to manufacturer recommendations. Maintenance staff was in-serviced regarding medication refrigerators in the medication room requiring an affixed locked box to store narcotics. 4. The DON or designee will monitor each nurse's station medication cart weekly for three months ensure facility policy and procedures are being followed. The unit manager will check weekly that	

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F 761	Continued From page 67 During an interview with the surveyor on 06/03/19 at 1:07 PM, the Director of Nursing stated that the [redacted] vials should have been dated when they were opened, both on the medication storage bottle and the [redacted] vial. She stated that the [redacted] would expire in 28 days after it was opened. She lastly stated that there should not have been a cup of unlabeled loose medications in the medication cart. During a follow-up interview with the surveyor on 06/06/19 at 09:00 AM, the DON stated that the UM, ADON and DON are all responsible to look over the medication carts for expired medications. During an interview with the surveyor on 06/06/19 at 11:09 AM, a [redacted] LPN stated that she would look at the [redacted] vials for the expiration date on the vial label and the plastic medication storage bottle but that she did not routinely look over the medication cart for expiration dates. The LPN stated that the [redacted] vials were good for 28 days after they are opened. She also stated that she did attend an in-service in 2019 for medication carts but could not recall specifics as to when the medication cart should be checked. Review of an undated Consultant Pharmacy "Med Cart Preparation for Med Pass" In-service documentation revealed the following: Nurses should have checked through the Med Cart daily and ensured that all [redacted] vials with shortened expiration dates are dated upon opening. Review of the "Medication Storage Policy," dated 05/27/19, revealed that the nursing staff was responsible for maintaining storage in a safe manner and that the facility will not use outdated	F 761	the narcotic box is permanently affixed to the medication refrigerator in the medication room. Findings will be reported at the next quarterly QA meeting.	

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F 761	Continued From page 68 drugs. 2. On 05/29/19 at 09:27 AM, the surveyor toured the [redacted] Medication Storage Room with LPN/UM #2 and observed a locked narcotic box inside the medication refrigerator. The narcotic box was attached to the inside wire rack with a long metal cable wrapped around the rack. The surveyor was able to remove the narcotic box to the outside of the refrigerator and hold in their hands. LPN/UM #2 stated that she was not aware that the narcotic box had to be affixed in the refrigerator. NJAC: 8:39-29.4(a)(h)	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		7/8/19

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F 880	Continued From page 69	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 70 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure a resident's [redacted] was properly secured to minimize the potential for transmission of infection. This deficient practice was identified for 1 of 1 resident reviewed for [redacted] use (Resident #80) and was evidenced by the following: According to the Face Sheet, Resident #80 was admitted to the facility on [redacted] with diagnoses including but not limited to; [redacted]. Review of Resident #80's June 2019 Physician's Order Sheet revealed an order for an [redacted] Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that the resident had an [redacted] On 06/03/19 at 11:20 AM and on 06/05/19 at 08:15 AM, the surveyor observed Resident #80 lying in bed. The resident's [redacted] was laying directly on the floor. On 06/05/19 at 08:21 AM, a Certified Nurses Aide (CNA) was present in the resident's room. The	F 880	1. A new [redacted] was provided for Resident #80 and the [redacted] placed inside the [redacted] 2. All residents have the potential to be affected by this deficient practice of failing to ensure a resident's [redacted] is properly secured to minimize the potential for transmission of infection. 3. All nurses and CNAS were in-serviced regarding the proper maintenance of an indwelling catheter and how it this relates to decreasing the risk of infection. 4. The DON or designee will monitor all residents with [redacted] weekly for four weeks to ensure proper maintenance of the [redacted]. Findings will be reported at the next quarterly QA meeting.	

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F 880	Continued From page 71 surveyor asked the CNA about the resident's [redacted]. At that time, the CNA observed the [redacted] on the floor. She stated the hook was missing from the [redacted] and that the [redacted] was to be hung on the bed and should not be on the floor. The CNA located the hook to the [redacted] and then hung the [redacted] on the bed frame. During an interview with the surveyor on 06/05/19 at 10:12 AM, the [redacted] Unit Manager (UM) stated that [redacted] should not be on the floor because of "cross contamination" due to "not knowing what is on the floor." During an interview with the surveyor on 06/05/19 at 12:12 PM, the Assistant Director of Nursing stated that [redacted] and/or tubing should not be on the floor because of the risk of infection. NJAC 8:39-19.4(a)(1-6)	F 880		