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ASTER CREEK NURSING AND REHABILITATION CENTER	**524 WARDELL ROAD TINTON FALLS, NJ 07753**

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F 000	INITIAL COMMENTS Complaint#: NJ146055 Census: 54 Sample Size: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 7/8/2021, 7/14/2021, and 7/19/2021, it was determined that the facility failed to provide a safe environment and assess a resident (Resident #4) who has a diagnosis of EX Order 26 § 4b1 and with a Physician's Order for continuous use of EX Order 26 § 4b1 when the resident's roommate (Resident #1) was EX Order 26 § 4b1 in their room with Resident #2 on EX Order 26 § 4b1, while Resident #4's EX Order 26 § 4b1 was in use. The facility also failed to provide a safe environment and accurately reassess Resident #1 and Resident #2, who were identified as EX Order 26 § 4b1 and had multiple infractions and violated the facility's EX Order 26 § 4b1 and EX Order 26 § 4b1 contract agreement by EX Order 26 § 4b1 in their rooms. There was no documented evidence in the Care Plans to	F 000		

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

Electronically Signed | 08/06/2021

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

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determine that interventions were in place and were evaluated for their effectiveness after each EX Order 26 § 4b1 violation and to ensure, Resident #1 was kept safe from harm on [redacted] when Resident #1 and Resident #2 were both EX Order 26 § 4b1 in Resident #1's room and Resident #2 EX Order 26 § 4 Resident #1 on the EX Order 26 § 4b1 with a EX O EX Order 26 § 4b1. The facility also failed to provide all staff educational training on the EX Order 26 § 4b1 policy, what to do if residents were found EX Order 26 § 4b1 in EX Order 26 § 4b1 areas and when EX Order 26 § 4b was being used after the EX Order 26 § 4b1 incident occurred. The facility's failure to revise and implement the residents' Care plans to avoid a EX Order 26 § 4b1 while a resident was on continuous use of EX Order 26 § 4b1 on three previous occasions created an unsafe environment for EX Order 26 § 4b1 [redacted]. The facility also failed to follow its Policies titled "Resident EX Order 26 § 4b1 Policy" and "EX Order Prevention."

This placed a threat to the safety and well-being of Resident #1, Resident #2, Resident #4, and all other residents residing at the facility, which resulted in an Immediate Jeopardy (IJ) situation. The IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) on 7/14/2021 at 4:14 p.m. The Administrator and DON were presented with the IJ template that included information on the issue. The IJ began on 6/13/2021 at 1:30 a.m., upon the second EX Order 26 § 4b1 violation incident when Resident #4 was present and on continuous EX Order 26 § 4b and when Resident #1 was EX Order 26 § 4 and continued until [redacted] at 9:51 a.m. when the facility alleged completed implementation of the elements in their IJ Removal Plan.

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F 000	Continued From page 2 On 7/19/2021, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating all facility staff on smoking and reporting all smoking to administration for residents who smoke within the facility or in their rooms, in residents' rooms with Oxygen, and the danger of smoking with oxygen present. So the noncompliance remained on 7/19/2021 for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following: Resident #1 was still in the facility but was on a [redacted] since he was caught [redacted] again on [redacted] during 15 minutes checks.	F 000		
F 657 SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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 657		7/20/21

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F 657	Continued From page 3 (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: COMPLAINT#: NJ146055 Based on observations, interviews, medical record reviews, and review of other pertinent facility documentation on 7/8/2021, 7/14/2021, and 7/19/2021, it was determined that the facility failed to update, revise and implement care plan interventions for residents who had multiple smoking infractions and violated the facility's smoking contract and smoking policy by smoking in their rooms. The facility also failed to follow its policy titled "Residents/Patients Care Plans." This deficient practice was evident in 3 of 4 care plans reviewed (Resident #1 and Resident #2) and was evidenced by the following: Review of the Medical Records (MRs) were as follows: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: EX Order 26 § 4b1 [redacted] According to the Minimum Data Set (MDS), an	F 657	1. Resident #1 discharged from the facility on [redacted] Resident #2 discharged from the facility on [redacted] Prior to the discharge both residents #1 and #2 care plans were updated, revised and implemented to reflect their smoking infractions, including interventions. Care Plan for resident #4 was updated, revised and implemented in ensure safety from smoke inhalation. 2. All residents that are smokers, have the potential of being affected by this practice. Care Plans were reviewed, revised and implemented in ensuring that all smoker's infractions and interventions are reflected on their Care Plans. 3. All nursing staff were educated in ensuring that all smoking infractions as well as any other unsafe incidents are updated on the residents care plan in a timely manner including implementation of interventions. During the clinical morning meeting, the IDT team will meet to discuss and review all incidents of smoking and other unsafe incidents of residents from prior day, ensuring that those Care Plans are reviewed, revised and implemented as needed including interventions.	

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F 657	Continued From page 4 assessment tool dated [redacted], Resident #1 had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident was EX Order 26 § 4b1. The MDS also showed Resident #1 was independent with ADLs and was a current EX Order 26 § 4b1. The Surveyor reviewed the Interdisciplinary Progress Notes (IPNs) for May, and June 2021, which reflected Resident #1 had [redacted] incidents of EX Order 26 § 4b1 in the bathroom. The IPNs reflected the following: A review of Resident #1's Interdisciplinary Progress Note (IPN) dated 5/7/2021, written by the Licensed Practical Nurse (LPN #2), revealed the resident admitted to EX Order 26 § 4b1 in his/her EX Order 26 § 4b1. However, there was no documentation in the resident's medical record (MR) of education being provided, an investigation completed, or violation warning for the EX Order 26 § 4b1 violation. A review of a second IPN showed a "late entry" note dated 6/20/2021 at 2:00 a.m., written by LPN #1. The IPN revealed at 1:30 a.m., on [redacted] Resident #1 and Resident #2 were EX Order 26 § 4b in Resident #1's room while Resident #4 had his/her EX Order 26 § 4b on, and the resident was asleep. According to the IPN, LPN #1 educated Resident #1 and Resident #2 about the dangers of EX Order 26 § 4b1 in the room with EX Order 26 § 4b present. The IPN also indicated, the resident's room was searched, there was nothing found, and Resident #2 returned to his/her room on another unit. The IPN also included that the incident was reported to the DON. A review of Resident #1's "Physician's Orders"	F 657	4. The DON/designee will be auditing all incidents to ensure that the care plans have been updated with interventions. This audit will be done on a daily basis for the first 2 weeks and twice daily for a week for the next 4 weeks, then weekly for the next 3 months. The results of this audit will be shared with the Quality Assurance team at the monthly and quarterly meetings who will make further recommendations based on the results of the audit.	

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dated 6/14/2021 revealed the following order: "Apply EX Order 26 § 4b1 [redacted]"

A review of the "Treatment Administration Record (TAR)" dated 06/2021 revealed the treatment was administered as ordered.

A review of the resident's Care Plan (CP) initiated on 5/5/2021 reflected that Resident #1 was a [redacted]. The CP also revealed the resident "[redacted] in (his/her) bathroom on [redacted] and was counseled." Further review of the CP under "Goal": showed, "I will adhere to (the) facility [redacted] policy, I will not suffer injury from unsafe [redacted] practices through the review date 5/5/2021." Further review of the CP showed under "Interventions": "I require supervision while [redacted], I will be instructed about [redacted] risks and hazards and about [redacted] cessation aids that are available, I will be instructed about the facility policy on [redacted]: locations, times, safety concerns, My [redacted] supplies are stored with the activity department. Notify charge nurse immediately if it is suspected that I have violated facility [redacted] policy, observe my clothing and skin for signs of [redacted] burns."

Further review of Resident #1's CP showed no revision or updates to Resident #1's CP for the following [redacted] infractions:

In the first [redacted] violation incident on [redacted], the resident was found with [redacted] materials in the resident's possession, including an [redacted] and one EX Order 26 § 4b1 .

The second [redacted] violation incident occurred on [redacted] when Resident #1 was [redacted] in

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his/her room and was found with an EX Order 26 § 4b1 of EX Order 26 § 4b1 and EX Order 26 § 4b1 .

The third EX Order 26 § 4b1 violation incident occurred on ., and a fourth EX Order 26 § 4b1 violation incident occurred that same day at 7:00 a.m. when the resident was EX Order 26 § 4 by Resident#2. However, there was only one form dated , which staff confirmed was for the incident.

After the 6/13/2021 incident, when the resident was EX Order 26 § 4, he/she was still found having a fifth EX Order 26 § 4b1 violation incident on 1 of EX Order 26 § 4b1 in the room while Resident #4 was on EX Order 26 § 4b .

At the time of the survey, the facility completed no EX Order 26 § 4b1 infractions forms for Resident #1's violations on , and for the . occurrence.

During a phone interview on 7/19/2021 at 12:37 p.m., LPN #2 stated that on , she EX Order 26 § 4b1 coming from resident #1's room, and she told the Nursing Supervisor. The Surveyor attempted to contact the Nursing Supervisor at the time of the survey but received no response.

2. According to the AR, Resident #2 was admitted to the facility on EX Order 26 § 4b1 with diagnoses which included but were not limited to: EX Order 26 § 4b1

According to the MDS, dated 4/23/2021, Resident #2 had a BIMS score of EX O / which indicated

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the resident was EX Order 26 § 4b1. The MDS also showed Resident #2 was independent with ADLs and was a current EX Order 26 § 4b1.

The Surveyor reviewed the IPNs for [redacted] and [redacted] 2021, which revealed Resident #2 had two EX Order 26 § 4b1 incidents in the bathroom. The IPNs reflected the following:

A review of Resident #2's IPN dated 6/14/2021 revealed a note written by the Social Worker (SW) that indicated Resident #2 EX Order 26 § 4b1 Resident #1 with a EX Order 26 § 4b1. According to the IPN, the SW asked Resident #2 to go to the hospital due to the resident's EX Order 26 § 4b1; however, the resident refused. The IPNs also included that the SW contacted the Crisis Center to screen and evaluate the resident. Resident #2 was to be sent to EX Order 26 pending hospital placement.

A review of the "EX Order 26 § 4b1" signed by Resident #1 on 5/3/2021, and Resident #2 on 4/19/2021, reflected both residents agreed to the terms of the contract, which included "1. No Resident is permitted to have any cigarettes, cigars, pipes, lighters, matches or any flammable device that can be used to light up smoking items. 2. To protect the safety of all residents and staff, if it is reported or known that a Resident has EX Order 26 § 4b1 materials in their possession, located in his/her room, and or located in their belongings, the resident will be notified, and their room will be searched by at least two (2) representatives of the facility, with or without the resident's permission .... (and) 5. EX Order 26 § 4b1 will ONLY be allowed in the designated area located on the patio off the main dining room."

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A review of an untitled statement written by the Housekeeping staff, dated 5/21/2021, indicated that he observed Resident #2 EX Order 26 § 4b1 in another resident's (Resident #1 & Resident #4) room on [redacted]

During an interview on 7/14/2021 at 2:15 p.m., the Housekeeper staff explained on the night of 5/21/2021; I could EX Order 26 § 4b1 from the hallway; when I entered the room and opened the bathroom door, I saw Resident #1 and Resident #2 with a EX Order 26 § 4b1. The Housekeeping staff stated Resident #4 was in the room with the [redacted]; I told them they could blow the building up.

A review of the Resident's CP initiated on 4/21/2021 reflected that Resident #2 was a EX Order 26 § 4b [redacted]. The CP also showed under "Goal": "I will adhere to (the) facility smoking policy, I will not suffer injury from unsafe smoking practices through the review date. Further review of the CP showed under "Interventions": "I require supervision while smoking; I will be instructed about smoking risks and hazards and about smoking cessation aids that are available, I will be instructed about the facility policy on EX Order 26 § 4b1: locations, times, safety concerns, My EX Order 26 § 4b1 supplies are stored with the activity department, Notify charge nurse immediately if it is suspected that I have violated facility EX Order 26 § 4b1 policy, observe my clothing and skin for signs of EX Order 26 § 4b1."

Further review of Resident #2's CP showed no revision or updates to Resident #1's CP for the following EX Order 26 § 4b1:

In the first smoking violation incident on

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5/20/2021, the resident was found with EX Order 26 § 4b1 materials in his/her possession, including a EX Order 26 § 4b1 .

The second EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The third EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The fourth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident accepted EX Order 26 § 4b1 materials from another resident and then gave them to staff.

The fifth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The sixth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

There were no smoking violations presented to the Surveyor for Resident #2 at the time of the survey for the two EX Order 26 § 4b1 incidents on [redacted]

During an interview on 7/8/2021 at 3:31 p.m., in the presence of the Licensed Nursing Home Administrator (LNHA), the Director of Nursing stated the (Minimum Data Set) MDS Coordinator was responsible for updating the CP. The DON stated the MDS Coordinator updates the CP after incidents, quarterly and annually. The DON agreed Resident #1 and Resident #2's CP should have been updated after each EX Order 26 § 4b1 violation

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F 657	Continued From page 10 incident. During an interview on 7/14/2021 at10:53 a.m., in the presence of the DON, the LNHA stated the MDS Coordinator would update the CP or anyone could update it. A review of facility policy titled, "Residents/Patients Care Plans," with an original issue date 12/2020, revealed the following: Under "Policy": included: "Resident/patient Care Plan within the facilities is individualized, managed and directed by an interdisciplinary process team. The interdisciplinary team is inclusive of resident, resident's family and Care Plan team of the facility...Upon review of the clinical and personal needs of the resident/patient and the resident's/patient's acceptance into the facility; the goals and objectives for the resident will be established and will be done on an individualized basis in order to the resident's/patient's needs." Under "Procedure:" "...4. Care Plans are a dynamic ongoing process and will be updated on a continual basis...7. Care Plan process will be monitored and directed by the team and Discharge Planner...9. All Care Plan issues or problems are to be identified on an ongoing basis, through the IDC team...10. The nurse is advised to communicate/listen to residents/patients clinical report on a daily basis regarding changes pertaining to their Care Plan. Whenever there are changes with residents/patients, then the resident abilities checklist should be modified including the Care Plan, ASAP by the IDC team..." N.J.A.C.: 8:39-27.1 (a)	F 657		

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F 689 SS=K	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: C#: NJ146055 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 7/8/2021, 7/14/2021, and 7/19/2021, it was determined that the facility failed to provide a safe environment and assess a resident (Resident #4) who has a diagnosis of [redacted] and with a Physician's Order for continuous use of [redacted] when the resident's roommate (Resident #1) was [redacted] in their room with Resident #2 on [redacted] while Resident #4's [redacted] was in use. The facility also failed to provide a safe environment and accurately reassess Resident #1 and Resident #2, who were identified as [redacted] and had multiple infractions and violated the facility's smoking policy and smoking contract agreement by smoking in their rooms. There was no documented evidence in the Care Plans to determine that interventions were in place and were evaluated for their effectiveness after each smoking violation and to ensure, Resident #1 was	F 689	1. Resident #1 was placed on [redacted] minute checks o [redacted] was discharged from the facility. Resident #2 was placed on Q15 minute checks on [redacted] and then was subsequently placed on a [redacted] on [redacted] until the resident discharged from the facility on [redacted] Prior to Resident #1 and #2 discharges from the facility, the following interventions were implemented: Both resident #1 and #2□s rooms were searched each shift for any type of [redacted] paraphernalia to include the presence of [redacted] s [redacted]. Resident #1 and #2 prior to discharge were re-educated on the dangers of [redacted] in the facility especially in the presence of residents using [redacted] therapy. Both Care Plans for Resident #1 and #2 have been updated, revised and implemented to reflect their smoking infractions with interventions in place. Resident #4 was assessed to ensure that	7/24/21

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ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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F 689	Continued From page 12 kept safe from harm on [redacted] when Resident #1 and Resident #2 were both [redacted] in Resident #1's room and Resident #2 burned Resident #1 on the [redacted] with a [redacted] The facility also failed to provide all staff educational training on the [redacted] policy, what to do if residents were found [redacted] in [redacted] areas and when [redacted] was being used after the 6/13/2021 [redacted] incident occurred. The facility's failure to revise and implement the residents' Care plans to avoid a [redacted] accident while a resident was on continuous use of [redacted] on three previous occasions created an unsafe environment for serious injury, combustion, and fire. The facility also failed to follow its Policies titled "Resident [redacted] Policy" and "Fire Prevention." This placed a threat to the safety and well-being of Resident #1, Resident #2, Resident #4, and all other residents residing at the facility, which resulted in an Immediate Jeopardy (IJ) situation. The IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) on 7/14/2021 at 4:14 p.m. The Administrator and DON were presented with the IJ template that included information on the issue. The IJ began on 6/13/2021 at 1:30 a.m., upon the second [redacted] violation incident when Resident #4 was present and on continuous [redacted] and when Resident #1 was [redacted] and continued until [redacted] at [redacted]. when the facility alleged completed implementation of the elements in their IJ Removal Plan. On 7/19/2021, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility	F 689	no ill effects were experienced due to Resident #1 and #2 [redacted] in room where [redacted] therapy is being used. Resident #4 roommate is a [redacted] and he/she will not be assigned a roommate that is a [redacted]. 2. All residents have the potential to be affected by this practice. All residents that [redacted] were re-educated on the [redacted] policy, danger of [redacted] in rooms where oxygen therapy is being use, No [redacted] to be kept in their possession for the prevention of avoiding dangers to other residents residing in the facility. 3. In the event that a resident is found to have violated the facility [redacted] policy, interventions will be implemented immediately as appropriate. These may include [redacted] suspension, Q15 minute checks, room searches, checking the resident when returning from out on pass and/or other interventions as appropriate. All staff were in-serviced on the following: a. Facility [redacted] policy b. To ensure that no residents [redacted] in the facility c. The danger of [redacted] in the facility especially in rooms while oxygen therapy is being use. d. To report all incidents of [redacted] within the facility or any residents that are found with [redacted] paraphernalia on their possession to the Administrator/DON immediately for immediate action and update of Care Plan. 4. The DON/designee will be doing daily audits to ensure that the Q15 minute	

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ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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F 689	Continued From page 13 implemented the Removal Plan, which included educating all facility staff on [redacted] and reporting all [redacted] to administration for residents who [redacted] within the facility or in their rooms, in residents' rooms with [redacted], and the danger of [redacted] with [redacted] present. So the noncompliance remained on 7/19/2021, for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following: Resident #1 was still in the facility but was on a [redacted] since he was caught [redacted] again on [redacted] during 15 minutes checks. This deficient practice occurred for 3 of 4 sampled residents (Resident #1, Resident #2, and Resident #4) and was evidenced by the following: According to the "Timeline of Events (TLE)" on 6/14/2021 at approximately 8:00 a.m., the DON was making rounds on the unit when Resident #1 reported to the DON that on Sunday 6/13/2021 at 7:00 a.m., Resident #2 was in Resident #1's room [redacted]. The FRE revealed Resident #1 told the DON that Resident #2 burn the resident on the right arm with the lit pipe. The TLE indicated that Resident #1 [redacted] Resident #2 [redacted]. The TLE also revealed that the DON assessed the [redacted] of Resident #1 and noted a [redacted] to the resident's [redacted]; the Physician was notified, a treatment was ordered, and it was in progress. The TLE also revealed Resident #1 did not report the incident to the nurse on the unit and was informed by the DON he/she need to report all incidents that occur, especially those resulting in injury. The FRE also revealed that the SW interviewed all three residents (Resident #1, Resident #2, and Resident #4).	F 689	checks are being done for residents whom [redacted] and on 15 minutes check, and that rooms are being check on all three shift are in compliance. The Administrator/designee will do room checks daily on all residents that are [redacted] to ensure that there is absent of [redacted] odor present in rooms, and residents are abiding by the [redacted] policy by not [redacted] within the facility. These audits will be done daily for the first 2 weeks, twice a week for the next 4 weeks then weekly for the next 3 months. The results of these audits will be shared with the Quality Assurance team at the Monthly and quarterly meetings for further recommendations based on the results of the audits.	

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Further review of the FRE indicated Resident #2 was seen by the [redacted] an appointment with the [redacted] was scheduled, and assessments were ongoing to prevent additional episodes. The FRE included an interview conducted by the SW dated 6/14/2021 that revealed the following: Resident #1 stated on 6/13/2021 at 7:00 a.m., Resident #2 placed a lit [redacted] on Resident #1's [redacted] and showed the Social Worker (SW) the [redacted] on the [redacted] Resident #1 told the SW, Resident #2 [redacted] him/her because the resident wanted Resident #1's [redacted]. Resident #1 further stated that he/she was sleeping when this happened; he/she woke up because the resident's roommate (Resident #4) said, [redacted] Resident #1 told the SW he/she did not report it earlier because the resident did not want to get the nurses in trouble. According to the FRE, interviews conducted by the SW dated [redacted], Resident #2 denied the incident happened at first, and then the resident stated to the SW that he/she was [redacted]" and no one got [redacted]. The SW explained to Resident #2; the incident was serious since someone got [redacted]. Resident #2 stated he/she has too much time, so the resident gets into trouble. On 6/14/2021, the SW also interviewed Resident #4, the roommate of Resident #1, who stated he/she observed the incident of Resident #2 [redacted] the [redacted] of Resident #1 with a [redacted] on [redacted] 1 and told Resident #2 [redacted]

Review of the Medical Records were as follows:

1. According to the Admission Record (AR), Resident #4 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to:

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[redacted]

According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident # 4 had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. The MDS also showed Resident #4 was independent with Activities of Daily Living (ADLs) and was on [redacted].

A review of the resident's Care Plan (CP) initiated 12/8/2020 revealed under "Focus": "I have [redacted] (related to) [redacted], [redacted] syndrome." The CP also included under "Goal": "I will have no signs/symptoms of poor oxygen absorption through the review date." Also, under "Interventions": included,"... Encourage the proper use of [redacted] - a device used to assist with consistent breathing while sleeping) @ (at) [redacted], [redacted]: [redacted], (and) Provide [redacted] apparatus...."
Further review of Resident #4's CP initiated 12/8/2020, included under "Focus": "I have a dx [redacted]. I have been [redacted] for [redacted] on [redacted], [redacted], [redacted], and [redacted]. The most recent return from the hospital [redacted]" The CP showed under "Goal": "I will be free of signs/symptoms of [redacted] through

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review date." The CP also showed under "Interventions": "... Monitor for difficulty breathing [redacted]. Remind me not to push beyond endurance... Monitor for signs/symptoms of [redacted]: [redacted], [redacted] Notify MD (Physician) of changes..[redacted]: [redacted]."

A review of the Physician's Order (PO's) revealed Resident #4 had a physician's order (PO) dated [redacted] for [redacted] at [redacted] (per) M (minute) (by) [redacted]

A review of the Treatment Administration Record (TAR) for [redacted] reflected the above POs to administer supplemental [redacted] at [redacted] per [redacted], which was signed to reflect that the resident received the supplemental [redacted] constantly via nasal cannula every shift as ordered.

The Surveyor reviewed Resident #4's IPNs from [redacted] through [redacted]; there was no documented evidence that the resident was assessed after the [redacted] incidents with Resident #1 and Resident #2 on [redacted] at [redacted] and [redacted] and on [redacted], while Resident #4 was present in the room on [redacted].

During an interview on 7/8/2021 at 11:00 a.m., the Surveyor observed Resident #4 sitting on the bed with his/her [redacted] on [redacted] by [redacted]. Resident #4 stated the resident needs his/her [redacted], so it is always on, and he was on [redacted]. According to the resident in [redacted] (he could not recall the day or date), Resident #2 took a pipe and put it onto Resident #1. Resident #4

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stated the resident and Resident #1 were both in the room, and Resident #4 came over to visit Resident #1 before breakfast.

2. According to the "AR," Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: Current Episode [redacted] with [redacted]

According to the MDS dated [redacted], Resident #1 had a BIMS score of [redacted], which indicated the resident was [redacted]. The MDS also showed Resident #1 was independent with ADLs and was a current [redacted].

A review of the resident's CP initiated on [redacted] reflected that Resident #1 was a [redacted]. The CP also revealed the resident "[redacted] in (his/her) bathroom on [redacted] and was counseled." Further review of the CP under "Goal": showed, "I will adhere to (the) facility [redacted] policy, I will not suffer injury from unsafe [redacted] practices through the review date 5/5/2021." Further review of the CP showed under "Interventions": "I require supervision while [redacted], I will be instructed about [redacted] risks and [redacted] and about [redacted] aids that are available, I will be instructed about the facility policy on [redacted]: locations, times, safety concerns, My [redacted] supplies are stored with the activity department. Notify charge nurse immediately if it is suspected that I have violated facility smoking policy, observe my clothing and skin for signs of [redacted] burns."

The Surveyor reviewed the Interdisciplinary

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Progress Notes (IPNs) for [redacted] and [redacted], which reflected Resident #1 had two incidents of [redacted] in the bathroom. The IPNs reflected the following:

A review of Resident #1's Interdisciplinary Progress Note (IPN) dated [redacted] written by the Licensed Practical Nurse (LPN #2), revealed a [redacted] of [redacted] was noted in the resident's bathroom. The IPN also revealed a [redacted] were obtained and placed in the medication cart. According to the IPN Resident #1 admitted to [redacted] in his/her bathroom.

A review of a second IPN showed a "late entry" note dated 6/20/2021 at 2:00 a.m., written by LPN #1. The IPN revealed at [redacted] Resident #1 and Resident #2 were smoking in Resident #1's room while Resident #4 was asleep with the [redacted] on. According to the IPN, LPN #1 educated Resident #1 and Resident #2 about the dangers of [redacted] in the room with [redacted] present. The IPN also indicated the room was searched, nothing was found, and Resident #2 returned to his/her room on another unit. The IPN also included that the incident was reported to the DON.

A review of Resident #1's "Physician's Orders" dated [redacted] revealed the following order: "[redacted]"

A review of the "Treatment Administration Record (TAR)" dated [redacted] revealed the treatment was administered as ordered.

During an interview on 7/14/2021 at 9:30 a.m.,

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Resident #1 explained that he/she would lose EX Order 26 § 4b1 privileges for a week or two whenever the resident was caught EX Order 26 § 4b1 in his/her room. Resident #1 also stated, "every time I EX Order 26 § 4 in my room (Resident #4) was there with (his/her) EX Order 26 § 4b on, (Resident #4) EX Order 26 § 4b with me, sometimes we goes in the bathroom in the room and EX Order 26 § 4." Resident #1 also stated, "when (Resident #4) EX Order 26 § 4b (he/she) removes the EX Order 26 § 4b and leaves it in the room and go to the bathroom." Resident #1 continued to explain staff has educated the resident about EX Order 26 § 4b1 in the room when they found out he/she was EX Order 26 § 4b1. Resident #1 also stated, all staff probably found the resident EX Order 26 § 4b1 in his/her room at some point, "because [redacted]

During a phone interview on 7/19/2021 at 12:37 p.m., LPN #2 stated that on [redacted], she EX Order 26 § 4b1 coming from resident #1's room, and she told the Nursing Supervisor. The Surveyor attempted to contact the Nursing Supervisor at the time of the survey but received no response.

The Surveyor reviewed the untitled facility's forms for EX Order 26 § 4b1 infractions, which revealed Resident #1 violated the EX Order 26 § 4b1 contract and had the following EX Order 26 § 4b1 violations:

In the first EX Order 26 § 4b1 violation incident on [redacted], the resident was found with [redacted] materials in his/her possession, including an EX Order 26 § 4b1 and one EX Order 26 § 4b1.

The second EX Order 26 § 4b1 violation incident occurred on [redacted] when Resident #1 was EX Order 26 § 4b1 in his/her room and was found with an empty EX Order 2 [redacted]

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The third EX Order 26 § 4b1 violation incident occurred on 6/13/2021 at 1:30 p.m., and a fourth EX Order 26 § 4b1 violation incident occurred that same day at 7:00 a.m. when the resident was [redacted] by Resident#2. However, there was only one form dated [redacted], which staff confirmed was for the [redacted] incident.

After the 6/13/2021 incident, when the resident was [redacted], he/she was still found having a fifth EX Order 26 § 4b1 violation incident on [redacted] of EX Order 26 § 4b1 in the residents room while Resident #4 was on [redacted].

The Surveyor reviewed the EX Order 26 § 4b1 binder presented during the survey; no EX Order 26 § 4b1 infractions were completed for Resident #1's violations on [redacted], [redacted] and [redacted] occurrence.

3. According to the AR, Resident #2 was admitted to the facility on [redacted] with diagnoses that included but were not limited to:
EX Order 26 § 4b1 [redacted].

According to the MDS, dated [redacted], Resident #2 had a BIMS score of [redacted] which indicated the resident was EX Order 26 § 4b1. The MDS also showed Resident #2 was independent with ADLs and was a current EX Order 26 § 4b1.

A review of the Resident's CP initiated on 4/21/2021 reflected that Resident #2 was a smoker. The CP also showed under "Goal": "I will adhere to (the) facility EX Order 26 § 4b1 policy, I will not suffer injury from unsafe EX Order 26 § 4b1 practices

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through the review date. Further review of the CP showed under "Interventions": "I require supervision while [redacted]; I will be instructed about [redacted] risks and hazards and about [redacted] cessation aids that are available, I will be instructed about the facility policy on [redacted]: locations, times, safety concerns, My [redacted] supplies are stored with the activity department, Notify charge nurse immediately if it is suspected that I have violated facility [redacted] policy, observe my clothing and skin for signs of [redacted] burns."

The Surveyor reviewed the IPNs for [redacted] and [redacted] which revealed that Resident #2 had two smoking incidents in the bathroom. The IPNs reflected the following:

A review of Resident #2's IPN dated [redacted] revealed a note written by the Social Worker (SW) that indicated Resident #2 [redacted] Resident #1 with a [redacted]. According to the IPN, the SW asked Resident #2 to go to the [redacted] due to the resident's [redacted]; however, the resident [redacted] The IPNs also included that the SW contacted the [redacted] to [redacted] the resident. Resident #2 was to be sent to [redacted]

There was no documentation in the IPN about the 6/13/2021 incident at 1:30 p.m., indicating that the resident's assigned nurse was aware and the facility's policy and procedure were implemented for [redacted] in [redacted] areas.

A review of the "[redacted] Contract" signed by Resident #1 on [redacted], and Resident #2 on [redacted] reflected both residents agreed to the

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terms of the contract, which included "1. No Resident is permitted to have any [redacted], [redacted]. 2. To protect the safety of all residents and staff, if it is reported or known that a Resident has [redacted] materials in their possession, located in his/her room, and or located in their belongings, the resident will be notified, and their room will be searched by at least two (2) representatives of the facility, with or without the resident's permission .... (and) 5. [redacted] will ONLY be allowed in the designated area located on the patio off the main dining room."

A review of an untitled statement written by the Housekeeping staff, dated 5/21/2021, indicated that he observed Resident #2 [redacted] in another resident's (Resident #1 & Resident #4) room on [redacted] and [redacted]

During an interview on 7/14/2021 at 2:15 p.m., the Housekeeper staff explained on the night of [redacted] I could [redacted] from the hallway; when I entered the room and opened the bathroom door, I saw Resident #1 and Resident #2 with a [redacted]. The Housekeeping staff stated Resident #4 was in the room with the [redacted] on; I told them they could blow the building up.

The Surveyor reviewed the untitled facility's forms for smoking infractions, which revealed Resident #2 violated the [redacted] contract and had the following [redacted] violations:

In the first [redacted] violation incident on [redacted], the resident was found with [redacted]

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materials in his/her possession, including a EX Order 26 § 4b1.

The second EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The third EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The fourth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident accepted EX Order 26 § 4b1 materials from another resident and then gave them to staff.

The fifth EX Order 26 § 4b1 violation incident occurred on 5/24/2021 when the resident was EX Order 26 § 4b1 in another resident's room.

The sixth EX Order 26 § 4b1 violation incident occurred on 6/2/2021 when the resident was EX Order 26 § 4b1 in another resident's room.

The Surveyor reviewed the EX Order 26 § 4b1 binger presented during the survey; no EX Order 26 § 4b1 infractions were completed for Resident #2 at the time of the survey for the two EX Order 26 § 4b1 incidents occured on 6/13/2021.

A review of a form titled 'EX Order 26 § 4b1 Privileges" revealed the following:

First Offense: Written Warning, Second Offense: 2 days suspension of EX Order 26 § 4b1 privileges. Third Offense: one-week suspension of EX Order 26 § 4b1 privileges. Fourth Offense: 30-day suspension of EX Order 26 § 4b1 privileges. Fifth Offense: indefinite suspension of EX Order 26 § 4b1 privileges.

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During an interview on 7/8/2021 at 12:42 p.m., the SW stated Resident #2 told her on Sunday, 6/13/2021, the resident "EX Order 26 § 4b1 " and placed it onto Resident #1's [redacted] for fun. After the [redacted] incident, she educated the resident for over an hour. The SW explained she interviewed Resident #1, and the resident also thought it was [redacted]. But "(Resident #1) said it [redacted] at the time it happened." The SW also stated the nurses on the units check the residents' rooms after a [redacted] incident. The SW further explained before the incident on [redacted]; there were other issues with the residents [redacted] in the wrong places. According to the SW, when residents have [redacted] infractions, their [redacted] privileges were suspended for a month after the incident.

During an interview on 7/8/2021 at 1:28 p.m., the DON stated after the [redacted] incident; Resident #2 was constantly monitored by her when she does her rounds; it was her daily routine, but it was not documented anywhere.

During an interview on 7/8/2021 at 1:44 p.m., the Activity Director (AD) stated all residents who [redacted] sign a "EX Order 26 § 4b1 ," and she does a "EX Order 26 § 4b1 " on admission and quarterly for safety purposes. All [redacted] supplies were kept in her office in a locked cabinet. The AD explained residents' rooms are searched if there is a broken contract. The AD further explained the residents' rooms were thoroughly searched. According to the AD, during the search of Resident #2's room, she found an [redacted] and [redacted] for it and [redacted].

During an interview on 7/8/2021 at 1:56 p.m., the

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Surveyor observed the resident right arm with EX Order 26 § 4b1 and EX Order 26 § 4b1. Resident #1 stated, "my friend (Resident #2) EX Order 26 § 4 me; I was asleep and heard don't do that. ...." Resident #1 explained Resident #2 had 'EX Order 26 § 4b1 " The resident also stated Resident #2 came into the resident room and EX Order 26 § 4b1; it shocked me awake." Resident #1 also said the resident told the nurse right away but could not recall who the nurse was, which was a conflict between LPN #1 interview and the facility's statement.

During an interview on 7/8/2021 at 2:53 p.m., LPN #1 indicated he did not know about Resident #1 and Resident #2 EX Order 26 § 4b1 in Resident #1's room. He was not aware of Resident #1 being EX Order 26 § 4 by Resident #2 on until the DON told him about it at a later date. However, he could not recall the date at the time of the survey. However, during a second interview on 7/14/2021 at 9:55 a.m., LPN #1 admitted to being aware of Resident #1 EX Order 26 § 4b1 in the room. The LPN explained he wrote the incorrect date of 6/20/2021 in the resident's chart; he wrote the note on , the day after the EX Order 26 § 4b1 incident occurred. LPN #1 further explained that at 1:30 a.m., he EX Order 26 § 4 coming from Resident #1's and Resident #4's room. According to the LPN, he did not discover any EX Order 26 § 4b1 EX Order 26 § 4b1 when he searched the room. He also did not notify Resident #2's nurse on unit of the EX Order 26 § 4b1 incident to initiate a search in Resident #2's room. LPN #1 also explained he educated both Resident #1 and Resident #2 on the dangers of EX Order 26 § 4b1 with EX Order 26 § 4b present; the building could go on EX Orde, and it could cause an EX Order 26 § 4b1.

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During an interview on 7/8/2021 at 3:02 p.m., when asked how the resident was monitored, Certified Nursing Assistant (CNA#1), assigned to Resident #2, stated she keeps an eye on the resident; if the resident leaves his/her room, she notifies the nurse.

During an interview on 7/8/2021 at 3:31 p.m., the LNHA stated that staff were doing frequent checks of Resident #2 after the incidents in [redacted].

During an interview on 7/8/2021 at 4:15 p.m. the LNHA, stated Resident #2 should not have been smoking in the room with Resident #4. The DON stated the [redacted] could have caused a fire. Both the Administrator and the DON indicated that they spoke to Resident #2 every day about [redacted]. When asked by the Surveyor if there were education provided to staff after the incident, the DON stated that there were no staff educations on [redacted] after the [redacted] incident.

During an interview on 7/8/2021 at 5:45 p.m., the LNHA stated he tried to do q (every) 15 minutes checks on Resident #2, but the resident was too [redacted]; therefore, the checks could not be done there were gaps in the documentation. The Administrator also stated the staff knew to watch Resident #2. However, no documentations were provided during the survey or observed in the resident's medical records indicating the checks were consistently implemented.

During an interview on 7/14/2021 at 9:25 a.m., Resident #2 stated, "I smoked Marijuana a lot before I came here. Now I only [redacted] once in a while. I have a connection from the outside who brings it in for me. Friends and family

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bring me in EX Order 26 § 4b1. I usually EX Order 26 § 4 it on the patio. When I EX Order 26 § 4, I have to [redacted] it."

During an interview on 7/14/2021 at 10:38 a.m., the LNHA stated after the [redacted] incident, Resident #2 was suspended for 30 days from EX Order 26 § 4b1. However, after 2-3 weeks, the resident's EX Order 26 § 4b1 plan was reinstated for good behavior. The LNHA explained there were searches done on the resident's room. Still, there was nothing found, so since there were no issues, staff were monitoring Resident #2, just as an observation without documentation. The LNHA also explained he tried to monitor Resident #2, but it was impossible because Resident #2 was totally independent. The LNHA also stated if a resident had a smoking violation, it would be attached to the resident's EX Order 26 § 4b1 contract in the EX Order 26 § 4b1 binder.

During a tour on 7/14/2021 at 10:52 a.m., the Surveyor interviewed LPN #3, who stated, "I can EX Order 26 § 4b1 in Resident #2's) bathroom." The LPN further stated, "I'm an EX Order 26 § 4b1, so I know if someone's been EX Order 26 § 4b1." The Surveyor then entered Resident #2's room at [redacted] and smelled a strong odor of EX Order 26 § 4b1 in Resident #2's bathroom.

During an interview on 7/14/2021 at 10:53 a.m., in the presence of the LNHA, the DON stated she was not aware of Resident #1 and Resident #2 smoking in Resident #1's on [redacted] at [redacted] in the presence of Resident #4 who was on EX Order 26 § 4b. The LNHA also indicated he was unaware of this incident.

During an interview on 7/14/2021 at 12:53 p.m.,

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the LNHA stated no investigations were done for the [redacted] EX Order 26 § 4b1 violation for Resident #1 and the [redacted] EX Order 26 § 4b1 violation at [redacted] for Resident #1 and Resident #2 he was unaware they occurred.

During an interview on 7/14/2021 at 1:59 p.m., CNA #2, assigned to Resident #1, stated he was present when LPN #1 talked to Resident #1 and Resident #2 when they were EX Order 26 § 4b1 in the room with Resident #4's EX Order 26 § 4b on at [redacted] on [redacted]

On 7/14/2021 at 11:04 a.m., while in the lobby area, the Receptionist called the Surveyor over to the receptionist desk/office and stated, "every time I EX Order 26 § 4b1 at the receptionist desk, ninety-nine percent of the time the smell is coming from Resident #2's room. I can smell it now." The Receptionist further explained Resident #2 hides his/her cigarettes on top of the resident's [redacted], [redacted], and [redacted] The Receptionist further stated, "for some reason, when Resident #2 smokes in his/her room, I can smell it in my office. I'm concerned because it can seriously hurt someone who is on EX Order 26 § 4b."

A review of the facility policy titled "Resident EX Order 26 § 4b1 Policy" revised date 3/29/2021 revealed the following: Under "Policy" included "...maintains a EX Order 26 § free facility. Residents are permitted to EX Order 26 § only outdoors in the designated EX Order 26 § 4b1 area. No Resident is permitted to have lighters or matches on their person, in their room or any indoor area of the facility due to safety." Under "Procedure" included "...4. A comprehensive Resident Care Plan will be written for each resident with individualized

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interventions ...5. There is only one area designated as a Resident [redacted] area. The outside Resident [redacted] patio on the [redacted] floor; off the upstairs main dining room ...7. All Residents who [redacted] will be supervised during the [redacted] period. They will smoke only during established [redacted] times. They will not be allowed to possess any form of [redacted] or any manner in which to ignite [redacted]. The [redacted] times may be modified as needed, both for short term or long-term basis to ensure the safe and efficient operation of the facility and the safety and maximum quality of life for all Residents ...9. The Activity Director, activity staff/designees will store the Resident's [redacted] items in a secured area and distribute these items to Residents, as needed ...13. The use of [redacted] will only be allowed in the same locations as other [redacted] items. The activity staff/designee will hold the [redacted] and nay other supplies that ware necessary for the use of the [redacted] ...Residents receiving [redacted] therapy, are not permitted in the designated [redacted] area while [redacted] is in use or if [redacted] is near them at any time."

Review of the facility policy titled "Fire Prevention", Updated 6/5/2021 revealed the following: Under "Policy Statement" included "It is the policy of facility that all personnel participate in methods of fire prevention and to report any condition(s) that could result in a potential fire hazard." Under "Procedure" included "Fire prevention is the responsibility of all personnel, residents, visitors and the public alike. Should a fire hazard, or other condition that could develop into a fire hazard be discovered, it shall be reported to the Director of Maintenance immediately. All personnel must be alert for: ....

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F 689	Continued From page 30 EX Order 26 § 4b1 in unauthorized areas...the department director shall be responsible for the prompt investigation of such condition(s). Hazardous conditions must be corrected as soon as practical..." On 7/19/2021, the surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating all the facility staff on the Smoking Policy and auditing Resident #1 and Resident #2 with Q (every) 15 minutes checks Q (every) shift and all smokers with daily room checks. So the noncompliance remained on 7/19/2021 for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy based on the following: Resident #1 was still in the facility but was on a [redacted] since [redacted] was caught smoking again on [redacted] during 15 minutes checks. N.J.A.C.: 8.39- 4.1 (5) N.J.A.C.: 8.39 -11.2 (2) (i)	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: C#: NJ146055	F 867	1.Resident #1 discharged from the facility on [redacted]. Resident #2 discharged from the facility	7/28/21

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F 867	Continued From page 31 Based on interviews, medical record review, and review of pertinent facility documents on 7/8/2021, 7/14/2021, and 7/19/2021, it was determined that the facility failed to develop and implement a plan to address preventable events that adversely affect residents and the facility's environment in a Quality Assessment Assurance (QAA) program for 3 of 4 residents (Resident #1, Resident #2, and Resident #4) reviewed for [redacted]. This deficient practice was evidenced by the following: Review of the Medical Records were as follows: 1. According to the "Admission Record (AR)," Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: EX Order 26 § 4b1 [redacted] According to the Minimum Data Set (MDS) an assessment tool dated [redacted] Resident #1 had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident was EX Order 26 § 4b1. The MDS also showed Resident #1 was EX Order 26 § 4b1 [redacted] A review of the resident's Care Plan (CP) initiated on [redacted] reflected that Resident #1 was a [redacted]. The CP also revealed the resident "[redacted] in (his/her) bathroom on [redacted] and was counseled." Further review of the CP under "Goal": showed, "I will adhere to (the) facility	F 867	on [redacted] Resident #4 does not [redacted] The Quality Assurance team reviewed the smoking incidents at the Quality Assurance meeting that took place on July 28, 2021. 2. All residents have the potential to be affected by this practice. 3. The Quality Assurance team was educated in ensuring that all unsafe incidents are reported and communicated at the monthly and quarterly QA meetings, ensuring that the incidents are reflected in the meeting minutes. A concern log will be kept of all unsafe incidents or any other related issues which are concerns as they occur, ensuring that they are all address at the Quality Assurance meetings. 4. The Administrator/designee will review the QA meeting minutes and compare to the concern log to ensure that they were all addressed at the Quality Assurance meetings. This audit will be done following each QA meeting for the next 3 months and then quarterly for the following 3 quarters. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings who will be making further recommendations based on the results of the audit.	

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EX Order 26 § 4b1 policy, I will not suffer injury from unsafe EX Order 26 § 4b1 practices through the review date 5/5/2021." Further review of the CP showed under "Interventions": "I require supervision while EX Order 26 § 4b1, I will be instructed about EX Order 26 § 4b1 risks and hazards and about EX Order 26 § 4b1 cessation aids that are available, I will be instructed about the facility policy on EX Order 26 § 4b1: locations, times, safety concerns, My [redacted] are stored with the activity department. Notify charge nurse immediately if it is suspected that I have violated facility EX Order 26 § 4b1 policy, observe my clothing and skin for signs of EX Order 26 § 4b1."

The Surveyor reviewed the Interdisciplinary Progress Notes (IPNs) for May, and June 2021, which reflected Resident #1 had two incidents of EX Order 26 § 4b1 in the bathroom. The IPNs reflected the following:

A review of Resident #1's Interdisciplinary Progress Note (IPN) dated [redacted] written by the Licensed Practical Nurse (LPN #2), revealed a [redacted] of EX Order 26 § 4 was noted in the resident's bathroom. The IPN also revealed a EX Order 26 § 4 and EX Order 26 § 4b1 were obtained and placed in the medication cart. According to the IPN Resident #1 admitted to EX Order 26 § 4b1 in his/her bathroom.

A review of a second IPN showed a "late entry" note dated 6/20/2021 at 2:00 a.m., written by LPN #1. The IPN revealed at 1:30 a.m., on 6/13/2021, Resident #1 and Resident #2 were smoking in Resident #1's room while Resident #4 was asleep with the EX Order 26 § 4b on. According to the IPN, LPN #1 educated Resident #1 and Resident #2 about the dangers of EX Order 26 § 4b1 in the room with EX Order 26 § 4b present. The IPN also indicated the room was

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searched, nothing was found, and Resident #2 returned to his/her room on another unit. The IPN also included that the incident was reported to the DON.

The Surveyor reviewed the untitled facility's forms for EX Order 26 § 4b1 infractions, which revealed Resident #1 violated the EX Order 26 § 4b1 contract and had the following EX Order 26 § 4b1 violations:

In the first EX Order 26 § 4b1 violation incident on 5/20/2021, the resident was found with smoking materials in his/her possession, including an EX Order 26 § 4b1 and one EX Order 26 § 4b1 .

The second EX Order 26 § 4b1 violation incident occurred on 5/24/2021 when Resident #1 was EX Order 26 § 4b1 in his/her room and was found with an EX Order 26 § 4b1 .

The third EX Order 26 § 4b1 violation incident occurred on 6/13/2021 at 1:30 p.m., and a fourth EX Order 26 § 4b1 violation incident occurred that same day at 7:00 a.m. when the resident was burned by Resident#2. However, there was only one form dated 6/16/2021, which staff confirmed was for the 6/13/2021 incident.

After the 6/13/2021 incident, when the resident was burned, he/she was still found having a fifth EX Order 26 § 4b1 violation incident on 6/24/2021 of EX Order 26 § 4b1 in the residents room while Resident #4 was on EX Order 26 § 4b .

The Surveyor reviewed the smoking binder presented during the survey; no EX Order 26 § 4b1 infractions were completed for Resident #1's violations on 5/7/2021, 5/21/2021, and 6/13/2021 for the 1:30 a.m. occurrence.

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	315414	A. BUILDING _____ B. WING _____	C 07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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2. According to the AR, Resident #2 was admitted to the facility on [redacted] with diagnoses that included but were not limited to: EX Order 26 § 4b1 [redacted].

According to the MDS, dated 4/23/2021, Resident #2 had a BIMS score of [redacted]/15, which indicated the resident was EX Order 26 § 4b1. The MDS also showed Resident #2 was independent with ADLs and was a current EX Order 26 § 4b1.

A review of the Resident's CP initiated on 4/21/2021 reflected that Resident #2 was a smoker. The CP also showed under "Goal": "I will adhere to (the) facility EX Order 26 § 4b1 policy, I will not suffer injury from unsafe EX Order 26 § 4b1 practices through the review date. Further review of the CP showed under "Interventions": "I require supervision while EX Order 26 § 4b1; I will be instructed about EX Order 26 § 4b1 and EX Order 26 § 4b1 and about EX Order 26 § 4b1 aids that are available, I will be instructed about the facility policy on EX Order 26 § 4b1: locations, times, safety concerns, My EX Order 26 § 4b1 supplies are stored with the activity department, Notify charge nurse immediately if it is suspected that I have violated facility EX Order 26 § 4b1 policy, observe my clothing and skin for signs of EX Order 26 § 4b1 burns."

The Surveyor reviewed the IPNs for May and June 2021, which revealed that Resident #2 had two EX Order 26 § 4b1 incidents in the bathroom. The IPNs reflected the following:

There was no documentation in the IPN about the [redacted] indicating that

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	315414	A. BUILDING _____ B. WING _____	C 07/19/2021

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the resident's assigned nurse was aware and the facility's policy and procedure were implemented for EX Order 26 § 4b1 in Order 26 § 4b1 areas.

The Surveyor reviewed the untitled facility's forms for EX Order 26 § 4b1 infractions, which revealed Resident #2 violated the EX Order 26 § 4b1 contract and had the following EX Order 26 § 4b1 violations:

In the first EX Order 26 § 4b1 violation incident on 5/20/2021, the resident was found with EX Order 26 § 4b1 materials in his/her possession, including a EX Order 26 § 4b1 .

The second EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The third EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The fourth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident accepted EX Order 26 § 4b1 materials from another resident and then gave them to staff.

The fifth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

The sixth EX Order 26 § 4b1 violation incident occurred on [redacted] when the resident was EX Order 26 § 4b1 in another resident's room.

A review of a form titled 'EX Order 26 § 4b1 [redacted]" revealed the following:

First Offense: Written Warning, Second Offense:

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2 days suspension of [redacted] privileges. Third Offense: one-week suspension of [redacted] privileges. Fourth Offense: 30-day suspension of [redacted] privileges. Fifth Offense: indefinite suspension of [redacted] privileges.

3. According to the AR, Resident #4 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited to [redacted].

According to the MDS, an assessment tool dated 3/17/2021, Resident # 4 had a BIMS score of [redacted] which indicated the resident was [redacted]. The MDS also showed Resident #4 was independent with ADLs and was on [redacted] therapy.

A review of the resident's CP initiated 12/8/2020 revealed under "Focus": "I have [redacted] therapy r/t (related to) [redacted]." The CP also included under "Goal": "[redacted]
Also, under "Interventions": included,"... Encourage the proper use of [redacted]

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Further review of Resident #4's CP initiated 12/8/2020, included under "Focus": "I have a [redacted]. I have been [redacted] for [redacted] on [redacted], [redacted], [redacted], [redacted] and [redacted]. The most recent return from the hospital 6/1/2021." The CP showed under "Goal": "I will be free of signs/symptoms of [redacted] through [redacted] The CP also showed under "Interventions": "... Monitor for [redacted]. Remind me not to push beyond endurance... Monitor for signs/symptoms of acute respiratory insufficiency: [redacted], [redacted] nasal prongs as ordered."

A review of the Physician's Order (PO's) revealed Resident #4 had a physician's order (PO) dated [redacted] for [redacted] EX Order 26 § 4b1 [redacted]

A review of the Treatment Administration Record (TAR) for June 2021 reflected the above POs to administer supplemental [redacted] at [redacted], which was signed to reflect that the resident received the supplemental [redacted] constantly via [redacted] every shift as ordered.

The Surveyor reviewed Resident #4's IPNs from [redacted] through [redacted]; there was no documented evidence that the resident was assessed after the [redacted] incidents with Resident #1 and Resident #2 on [redacted] at [redacted]. and [redacted] and on [redacted], while Resident #4 was present in the room on [redacted].

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A review of the facility's QAA meetings dated March, April, May, and June 2021, indicated the above EX Order 26 § 4b1 infractions were not brought to QAA.

During an interview on 7/8/2021 at 4:15 p.m. the LNHA, stated Resident #2 should not have been EX Order 26 § 4b1 in the room with Resident #4. The DON stated the EX Order 26 § 4b1 could have caused a fire. Both the Administrator and the DON indicated that they spoke to Resident #2 every day about smoking. When asked by the Surveyor if there were education provided to staff after the incident, the DON stated that there were no staff educations on EX Order 26 § 4b1 after the 6/13/2021 incident.

During an interview on 7/14/2021 at 12:53 p.m., the LNHA stated no investigations were done for the 5/7/2021 EX Order 26 § 4b1 violation for Resident #1 and the 6/13/2021 EX Order 26 § 4b1 violation at 1:30 a.m. for Resident #1 and Resident #2 he was unaware they occurred.

During an interview on 7/14/2021 at 11:40 a.m., the LNHA stated "the last QAA meeting was in June, Smoking concerns would be brought up in QAA."

During a follow-up interview on 7/14/2021 at 12:05 p.m., the LNHA stated, "the minutes do not reflect the EX Order 26 § 4b1 concerns, it would have been brought up in QAA. The LNHA also explained " EX Order 26 § 4b1 concerns would also be discussed in the morning meetings." However, the facility does not keep morning meeting notes. The LNHA also stated, "we don't have an official safety

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committee."

Review of the facility's Assessment Tool dated 8/18/2017, revealed the following: Under "Requirement": Nursing facilities will conduct, document, and annually review a facility wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. Under "Purpose": The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Under "Staff training/education and competencies": 3.4 Facility provides staff training/education and competencies that are necessary to provide the care and support needed for our residents this training education is provided upon hire, as well as scheduled in-services education during the course of employment as well as annually. Facility provides training and competencies that include, but not limited to: Fire Prevention and Safety.

Review of the facility policy titled "Accident/Incident-Investigation and Reporting" dated 03/2021, indicated the following: Under "Policy Statement": All accidents involving residents, employees, visitors, vendors, etc. that occurred on the facility ground inside or outside shall be investigated and reported to the Administrator/designee." Under "Policy Interpretation and Implementation" included: 1) Nurses/designee or the department director shall promptly initiate the documented and investigate the incident/accident. 5) The Director of Nursing will inform the Administrator of all incidents/accidents reports received from nurses. 6) Incident/accident reports will be reviewed by

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F 867	Continued From page 40 the team for trends, root analysis and preventatives measures will be initiated for the prevention of farther occurrences." Review of the "EX Order 26 § 4b1 " dated, 3/9/2021, indicated the following: Under "Policy": [Facility] maintains a EX Order 26 § 4 free facility. Residents are permitted to EX Order 26 § 4 only outdoors in the designated EX Order 26 § 4b2 area. No Resident is permitted to have lighters or matches on their persons, in their room or any indoor area of the facility due to safety. Under "Procedure": #11. All smoking related incidents/accidents will immediately be reported to the Administration/designee. N.J.A.C 8:39-33.1(c)(d)(e)	F 867		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315414 (Y1)	A. Building B. Wing (Y2)	8/10/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTER CREEK NURSING AND REHABILITATION CENTER	524 WARDELL ROAD TINTON FALLS, NJ 07753

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 07/20/2021	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 07/24/2021	ID Prefix F0867 Reg. # 483.75(g)(2)(ii) LSC	Correction Completed 07/28/2021
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
7/19/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO