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	315124	A. BUILDING _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS STANDARD SURVEY: 05/09/19 CENSUS: 100 SAMPLE SIZE: 23 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 677 SS=B	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; 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 residents who depended on staff for grooming and hygiene were afforded the services according to their needs. This deficient practice was observed in 7 of 7 residents reviewed (Residents #16, #80, #37, #60, #2, #41, and #27) and is evidenced by the following: 1. During the initial tour of the facility, on 05/02/19 at 11:10 AM, the surveyor observed Resident #16 in an electric wheelchair in his/her room. The resident was wearing shorts which revealed a few [redacted]. Resident #16 explained that the [redacted] The surveyor observed a loose,	F 677	F-677 1. Resident #16, the [redacted] and as needed by the facility and facial hairs were trimmed. Resident #80, hair was cut and combed and shoes were purchased so they would be the same color. Resident #37, a new belt was purchased. Resident #60, self releasing seat belt was cleaned and hair was done. Resident #2, hair was done and resident was given clean non-skid socks. Resident #41 was provided with grooming. Resident # 27 nails were trimmed. A designated staff member will visit resident #16,80,60,2,41 and 27 on a weekly basis to address grooming needs.	6/12/19

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

Electronically Signed | 05/31/2019

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F 677	Continued From page 1 [redacted]. Resident #16 stated it was blood and commented, "I didn't wash it." The resident further explained that he/she usually washed the [redacted] in the bathroom sink. The surveyor also noticed that Resident #16 had long, unkempt facial hair. On 05/03/19 at 11:54 AM, the surveyor observed Resident #16 in the activity room. The resident again was [redacted] The resident stated that he/she was due for a hair cut and facial hair trim. Resident #16 explained that the employee who delivered supplies to the nursing units also cut the residents' hair. The resident stated that this supply person has to "make time for that. He's so busy, so, I gotta wait for him. He'll tell me a date and then we'll meet up in my room." Review of the Face Sheet indicated that Resident #16 was admitted to the facility on [redacted] and had diagnoses which included [redacted] Review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #16 scored [redacted] Review of Resident #15's Interdisciplinary Care Plan, dated reviewed on 11/18/18 and 02/16/19, revealed that the staff were to provide supervision with dressing Resident #16 and provide one person to assist with Activities of Daily Living	F 677	2. All residents have the potential to be affected when grooming, and clothing/foot wear is not up to standards. A review of other residents with the same issues were done and grooming/wardrobe attire was done. 3. An inservice was done for the nurses and the CNAs on grooming and appropriate attire for the residents. All staff was instructed to notify the Unit Manager if a resident is in need of new clothing. All staff were also instructed to report non-compliance so that the nurses can document accordingly. The facility staff member who the residents like to cut or trim their hair will be available one day a week for grooming only. 4. The Director of Nurses, Assistant Director of Nurses, and Unit Managers will choose 10 residents daily x 3 months, 5 residents weekly x 3 months, and 2 residents monthly x 3 months to ensure residents have proper grooming and that their clothing attire is up to standards. All findings will be reviewed at the Quality Assurance Meeting x 3 quarters.	

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F 677	Continued From page 2 including bathing, meal set up, nail clipping and transferring. On 05/08/19 at 12:45 PM, the surveyor observed that Resident #16 was wearing a [redacted] This event occurred after the surveyor had mentioned the [redacted] to facility staff on the previous day. The resident stated that it had been washed that day in the laundry. The surveyor interviewed the Certified Nursing Assistant (CNA) who was normally assigned to care for Resident #16 on 05/08/19 at 12:46 PM. The CNA named the male employee who usually took care of hair cuts and shaves. The CNA stated that she was not responsible for caring for the facial hair for the resident. The CNA also stated that she had noticed [redacted] on the resident's [redacted] "sometimes" and at those times she would take them off and get Resident #16 a [redacted]. The CNA stated that she had not noticed that the [redacted] was [redacted] recently and was not aware that the resident was washing the skin protector. 2. On 05/02/19 at 10:51 AM, the surveyor observed Resident #80 in the resident's room wearing two different shoes, one white athletic shoe and one black rubber shoe. During an interview at that time, the resident pointed out one other orthopedic sandal in the corner of the room, indicating that was the only other shoe he/she had. The resident's hair appeared long and uncombed. Resident #80 stated that the last time they scheduled him/her for a haircut, he/she had to go to the hospital. Resident #80 concluded, "The barber is a busy man."	F 677		

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The surveyor again observed Resident #80 in the dining room on 05/03/19 at 12:16 PM and on 05/06/19 at 12:17 PM. On both of these occasions the resident was wearing a white sneaker and a black shoe.

On 05/07/19 at 12:25 PM, the surveyor observed Resident #80 in the dining room wearing two different shoes. At that time the resident pointed to the white athletic shoe and stated that he/she received it from the Physical Therapy (PT) Department. When the surveyor inquired why he was wearing the black shoe, the resident stated that PT only had one white sneaker. The resident's hair appeared long and uncombed.

Review of the Face Sheet revealed that Resident #80 was admitted on [redacted] with a diagnoses including [redacted] The resident's two most recent MDS assessments, dated [redacted] and [redacted], included BIMS scores of [redacted]

On 05/08/19 at 12:07 PM, the surveyor interviewed the Social Worker (SW) regarding the resident's clothing, general appearance and amount of funds left in his/her personal needs account (PNA). The SW replied that the resident had "plenty of money." The surveyor reviewed the PNA Balance sheets which revealed that Resident #80 had more than $700 in the account.

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The SW also explained that a clothing company came to the facility six months ago. She stated that this company visited the facility in Winter and Summer and brought samples of clothing for residents to order. The SW stated that she also ordered resident's clothes from a discount department store on line. She added that around the holidays the facility received clothing donations. The SW also showed the surveyor a receipt for $54 from February, 2019 when she had placed an order for Resident #80. The receipt included slip-on shoes, pants and a shirt. The surveyor inquired about either a barber or beautician services at the facility. The SW replied that the beautician was "a little expensive. We have someone come in. The Activities Director will call her. I'll bring it up at the next residents' counsel meeting." The SW then provided the surveyor with a list of hair care prices offered to residents. The list included a barber cut for $10. The surveyor observed that shaving and beard trimming were not included on the price list. On 05/09/19 at 08:47 AM, the SW stated that the beautician had not been here since the new Activities Director started earlier this year.

On 05/08/19 at 12:32 PM, Resident #80 was in his/her room dressed in a hospital gown. The resident's hair was very closely cropped. Resident #80 liked the haircut that the facility employee provided. Resident #80 was still unshaven and stated that the man who cut his/her hair had no time to shave the resident this morning. The surveyor inquired about the shoes that were purchased in February. Resident #80 stated that the shoes did not fit.

On 05/08/19 at 12:40 PM, the surveyor interviewed the CNA who usually cared for

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Resident #80. She stated that the resident chose and usually put on shoes independently and the mismatched shoes were all that the resident had. The CNA stated that she usually shaved Resident #80 every other day.

On 05/08/19 at 01:27 PM, the SW stated that she was not aware that the shoes didn't fit Resident #80. She then stated that she would talk to the resident about getting another pair.

On 05/09/19 at 10:30 AM, the Regional Director presented the surveyor with a Screen/Referral Form from the PT Department, dated 08/02/17. The form indicated that the department provided Resident #80 with a [redacted], "as per ordered [sic] by [redacted] care nurse." At 11:06 AM, the Regional Director stated that they could try to find Resident #80 a sneaker that matched the orthopedic sneaker.

3. On 05/03/19 at 2:30 PM, the surveyor observed that Resident #37 was standing near the elevator on the lower level. At that time, the resident's pants zipper was unzipped. The surveyor observed that staff did not approach the resident to offer assistance.

On 05/07/19 at 12:33 PM, Resident #37 was standing at the nurse's station on the [redacted] wearing a blue dress shirt with a large stain on the back of the shirt. Resident # 37 kept repeating, "I can't get me a proper belt to fit my pants."

The surveyor observed that Resident #37 was standing by the nurse's station on 05/08/19 at 10:35 AM . The surveyor observed that the resident's pants were unzipped. At that time

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F 677	Continued From page 6 Resident #37 stated, "they don't zip and I can't find a proper belt to fit." On 05/08/19 at 12:53 PM, the surveyor observed that Resident #37 was wearing a different pair of pants that zipped properly. The surveyor then interviewed the CNA who normally cared for Resident #37. The CNA stated that he was not working at the facility on 05/07/19, when Resident #37 was dressed in the soiled blue shirt. He also stated that Resident #37 takes off his/her belt. The surveyor reviewed the medical record for Resident #37 which revealed the resident had a BIMS score of [redacted]. 4. On 05/02/19 at 09:39 AM, the surveyor observed Resident #60 slowly self-propelling his/her wheelchair through the [redacted] hallway. The resident was wearing a seatbelt across his/her lap. The surveyor observed that the black seatbelt was visibly soiled with a white residue. The surveyor further observed that the resident was unshaven and had long, unkempt hair. The surveyor observed Resident #60 on 05/08/19 at 10:13 AM, self-propelling his/her wheelchair on the ground floor. At this time, the resident was accompanied by the Occupational Therapist (OT). The resident's seatbelt was unbuckled and did not appear to be soiled. The surveyor	F 677		

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observed that there was a large stain on the resident's gray sweat pants in the lap area. The surveyor mentioned the soiled pants to the OT who had not noticed. The OT stated that Resident #60 did have coffee this morning. Then she told Resident #60 to wait while she got a clean pair of pants. The surveyor observed that the resident's hair still appeared long and disheveled.

The surveyor reviewed the resident's medical record. The 5/19 Physician's Order Form indicated that Resident #60 had a diagnosis of [redacted]. The Resident's most recent MDS, dated [redacted] included a BIMS score [redacted]

5. On 05/03/19 at 12:42 PM, the surveyor observed that Resident #2 was watching television in his/her room. The surveyor observed that the resident had gray, unkempt shoulder length hair. The resident stated that he/she didn't know when the barber or beautician came to the facility. The surveyor noted that Resident #2 was wearing the same non-skid yellow socks that were soiled with large black stains that he/she was wearing on the previous day.

The surveyor interviewed Resident #2 on 05/08/19 at 10:59 AM. The resident stated that he/she would usually go to a barber outside of the

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facility in another town for a haircut. The resident stated that no one ever offered to cut his/her hair at this facility. Resident #2 concluded that he/she would have a haircut in the facility, if possible, especially in the hot weather.

The surveyor reviewed the resident's medical record which revealed that Resident #2 was admitted to the facility on [redacted]. The most recent MDS, dated [redacted], included a BIMS score of [redacted]

On 05/09/19 at 09:05 AM, the surveyor observed that Resident #2 had gotten a very short hair cut. The resident grinned and stated that he/she felt "naked."

6. On 05/06/19 at 12:29 PM, the surveyor observed Resident #41 in the dining room. The surveyor observed that the resident's hair was long and uncombed. The surveyor observed that the resident was dressed in a blue sweatshirt that was covered with white flakes.

A review of Resident #41's most recent MDS, dated [redacted], revealed a BIMS score [redacted]

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[redacted]

On 05/08/19 at 10:39 AM, the surveyor observed that Resident #41 had gotten a shave and hair cut. The resident stated that he/she couldn't guess when his/her hair was last cut.

7. During the initial tour of the facility on 05/02/19 at 10:17 AM and 05/03/19 at 12:14 PM, the surveyor observed that Resident #27 had long fingernails, extending beyond the fingertips.

On 05/06/19 at 12:28 PM, the surveyor observed that the resident's fingernails were unchanged. On 05/06/19 at 01:16 PM, the surveyor spoke to the Unit Manager (UM) who said that Resident #27 frequently refused to have his/her nails cut. Later that day, the resident agreed to have the UM cut his/her nails if she provided the resident with a treat.

The surveyor reviewed the resident's medical record. The most recent MDS, dated [redacted], included a BIMS score of [redacted]

On 05/09/19 at 09:01 AM, the surveyor interviewed the CNA who usually cared for Resident #27. She stated that the resident let her trim his/her fingernails. The CNA offered no explanation why the resident's fingernails were

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allowed to grow so long without being trimmed.

On 05/09/19 at 10:35 AM, the surveyor interviewed the employee who had been cutting the resident's hair and trimming their facial hair. The employee stated that his official title was "QA" and that he was responsible for making sure that the nurses had their supplies. He stated that he began cutting residents' hair a year ago, when one resident asked him. Then, other residents began to ask him to cut their hair as well.

The QA reported to the surveyor that Resident #2 tapped him on the shoulder at the nurse's station and stated, "I liked the cut you gave me. I slept so good last night." During the course of the survey, the surveyor never observed Resident #2 leave the bedroom.

The QA stated that he does not charge for the haircut services and that residents ask him to cut their hair. He stated that sometimes he gets referrals from CNAs. The QA added that he just enjoyed helping the residents to look good.

On 05/09/19 at 11:00 AM, the surveyor reviewed the Rehabilitation and Nursing Home Admission Agreement which was provided for new residents upon admission. The following statement is included in this agreement on page 7, section G.: "Beauty/Barber Services. Services are provided in the Facility by a licensed beautician. Routine services can be arranged and charges can be billed monthly, or be charged to a personal needs account through the business office. Resident hereby consents to routine services by Facility beautician."

NJAC 8:39-4.1(a) 22; 27.2 (g); 27.3 (c)

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to apply splints as ordered by the physician for Resident #24, 1 of 1 residents reviewed for range of motion. This deficient practice was evidenced by the following: On 05/02/19 at 10:29 AM, during the initial tour of the facility, the surveyor observed Resident #24 lying in bed asleep with the [redacted] The surveyor observed a [redacted]	F 688	F-688 1. Resident #24 was evaluated by the therapy department for the timing of [redacted] which includes new orders for times on/off. The Care Plan was updated to reflect all current information in regards to [redacted] 2. All residents have the potential to be affected when resident devices ie: [redacted] An audit was done by the unit managers and therapy of all residents with devices and orderswere reviewed to encure clarity of orders and placement of devices. Care	6/12/19

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F 688	Continued From page 12 On 05/03/19 at 10:44 AM and 12:40 PM, the surveyor observed Resident #24 lying in bed with [redacted]. The surveyor observed a [redacted]. A review of Resident #24's History and Physical (H&P), dated [redacted] revealed that the resident was readmitted to the facility with diagnosis of [redacted] The H&P further indicated the resident had a [redacted] The surveyor reviewed the Physical Therapy Discharge Summary (Summary) for the dates of services 01/15/19-02/07/19. The Summary revealed under "Discharge Status and Recommendations: [redacted] Recommendations: It is recommended the patient [redacted] an [redacted] except during care in order to [redacted] " The surveyor reviewed the May 2019 Physician's Order Form which revealed an order dated 02/07/19 for [redacted]	F 688	plans were updated. 3. An in-service was done with the nurses and CNAs on ensuring devices are in place and care plans are updated accordingly. 4. The Director of Nurses, Assistant Director of Nurses,Unit Managers and nursing supervisor will ensure daily that all devices are placed on residents according to therapy recommendations and physician orders that include correct application and times, daily x 30 days, weekly ongoing. All findings will be reviewed at the Quality Assurance Meeting x 2 quarters.	

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F 688	Continued From page 13 Review of Resident #24's Interdisciplinary Care Plan (CP), initiated 03/29/19, revealed that the CP did not address the [redacted] On 05/06/19 and 05/07/19, the surveyor observed Resident #24 with the [redacted] On 05/08/19, the surveyor reviewed the May 2019 Treatment Record (TR), which revealed an entry for [redacted] The TR was signed by facility nursing staff daily on both the 7 AM-3 PM shift and 3 PM-11 PM shifts from 05/01/19 through 05/07/19. On 05/08/19 at 10:05 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) #1. CNA #1 informed the surveyor of the type of care that she provided to Resident #24. CNA #1 pulled back the resident's sheets and the surveyor observed that the resident [redacted] CNA #1 stated that the [redacted] when she provided care on 05/02/19 and 05/03/19. CNA #1 further stated that she thought the [redacted] must have recently been found and that she only observed the [redacted] in use in the past. CNA #1 further explained that the first time she saw the [redacted] was on 05/07/19 and thought that it must have been a new order. On 05/08/19 at 10:15 AM, the surveyor	F 688		

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F 688	Continued From page 14	F 688		

interviewed the Licensed Practical Nurse (LPN). The LPN stated that she thought that the CNAs were responsible for [redacted]. The LPN further stated that nurses weren't responsible for [redacted]

On 05/08/19 at 10:21 AM, the surveyor interviewed the Unit Manager (UM). The UM stated that the CNAs were responsible for [redacted] The UM further stated that sometimes therapy applied [redacted] to the residents. The UM reviewed Resident #24's May 2019 TR and was unable to identify the employee signatures to determine which staff member signed the TR on 05/02/19 and 05/03/19.

On 05/08/19 at 10:25 AM, the surveyor interviewed CNA #2 who was assigned to the resident and she stated that she never applied [redacted] to Resident #24. CNA #2 further stated that the 11 PM-7 AM shift must have put them on the resident because they were already on the resident at the beginning of the shift.

On 05/08/19 at 10:28 AM, the surveyor interviewed the LPN who confirmed that she signed Resident #24's TR for [redacted] on 05/03/19 but she did not [redacted]. The LPN further stated that she just signed that the [redacted] were on after therapy told her that the resident needed them. The LPN indicated that she spoke with the therapist sometime in the afternoon on 05/03/19.

On 05/08/19 at 11:59 AM, the surveyor interviewed the Director of Rehab (DOR). The DOR stated that Resident #24 was on Physical Therapy and was ordered both a [redacted]

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F 688	Continued From page 15 [redacted] The DOR stated that therapy was [redacted]. The DOR stated that the [redacted] The DOR stated that on 05/01/19, she noticed that there were som [redacted]. The DOR saw the resident's [redacted]. The DOR further stated that she spoke with the nurse and explained that it was beneficial for the resident to [redacted] NJAC 8:39 - 27.2(m)	F 688		
F 689 SS=D	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 observation, interview and record review, it was determined that the facility failed to a.) provide adequate supervision to a resident (Resident #91) who required assistance with Activities of Daily Living (ADLs), which resulted in a fall when the resident was left unattended in the shower room; and b.) provide a safe environment for a resident (Resident #24) by utilizing a power strip for the resident's medical care equipment.	F 689	F-689 1. The Agency CNA who left resident #91 alone in the shower room was removed from working at the facility by the former Director of Nurses. Resident #24, the power strip was removed and replaced. All medical equipment was plugged into the	6/12/19

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F 689	Continued From page 16 This deficient practice was identified for 2 of 2 residents reviewed for accidents and was evidenced by the following: On 05/09/19 at 08:30 AM, the surveyor reviewed an Incident Report (Report) dated 04/23/19. The Report reflected that staff informed the Registered Nurse (RN) that Resident #91 was found on the floor in the shower room on 04/23/19 at 3:25 PM. The Report further revealed the resident had [redacted], with first aid rendered, and that the doctor and family was notified. The Report further indicated that education was "provided to CNA [Certified Nursing Assistant] - no one is allowed to shower alone, absolutely no unassisted transfers." Review of the Nurse's Notes, dated 04/23/19 at 5:00 PM, revealed the RN assessed the resident and Resident #91 [redacted]. The note reflected that the resident was not in pain and that the doctor was notified. The surveyor reviewed the resident's Facesheet which revealed the diagnoses of [redacted]. The most recent Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident is [redacted].	F 689	appropriate wall outlets. 2. All residents have the potential to be affected when residents are left unattended and when medical equipment is not plugged into the appropriate outlets. The facility has ensured that when agency staff are utilized they will receive a full report and inservice prior to their shift. A review of all rooms was done to ensure medical equipment is plugged into the appropriate outlets. 3. The facility has made an inservice binder that will be reviewed snd signed prior to any agency CNA start of shift. This includes a Job discription which indicates that residents are never to be left alone in the shower room. An in-service was done to all Administrative staff on the proper use of outlets for medical equipment. 4. The Director of Nurses, Assistant Director of Nurses and nursing supervisors will ensure that any new agency CNA review and sign the agency binder in-service. The Administrator will review the completion of this binder daily to ensure the protocol is being followed x 2 quarters. All findings will be reported at the Quality Assurance meeting x 2 quarters. The Administrator or Maintenance Director will make rounds weekly ongoing to ensure proper use of outlets for medical equipment. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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F 689	Continued From page 17 The ongoing Interdisciplinary Care Plan (CP), initiated on 04/15/19, revealed the resident gets showered two times per week and required "one person assist" for wheelchair mobility. Review of Resident #91's CP, dated 04/15/19, revealed the resident was at risk for [redacted] The interventions include for a one person assist with ADLs and transfers. The CP evaluations, dated 04/15/19, included documentation that the resident continues to be a one person assist with ADLs and transfers related to [redacted] The Fall Risk Evaluation revealed that on 04/22/19 and 04/23/19, Resident #91 was assessed as being at high risk for falls. On 05/09/19 at 08:56 AM, the surveyor interviewed the former Director of Nursing (DON). The DON stated that an Agency CNA let the resident into the shower room and left the resident in the shower room. The DON further stated that she educated and counseled the Agency CNA. The DON stated the Agency CNA was very apologetic, saying that she knows better and that she should not have left the resident. The DON further stated that when an Agency CNA comes into the facility, she specifically would tell them that the shower rooms are locked with a combination key pad. The DON stated that she would give the combination to the Agency CNA and instruct the Agency CNA that "no resident" is allowed to take a shower by themselves and that "all residents must be supervised."	F 689		

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F 689	Continued From page 18 On 05/09/19 at 09:40 AM, the surveyor requested to interview Resident #91 with an interpreter, as the resident spoke both [redacted]. The Administrator made arrangements for the interview. The surveyor further requested from the facility a copy of any education provided to the Agency CNA. On 05/09/19 at 10:10 AM, the surveyor interviewed Resident #91 with an interpreter, an employee from Environmental Maintenance. Resident #91 confirmed a staff member opened the shower door and that he/she was left alone in the shower room. On 05/09/19 at 10:30 AM, the surveyor interviewed Resident #91's assigned CNA. The CNA stated that she stays with the resident and assists the resident with bathing and dressing. The CNA further stated, "It is common sense not to leave a resident in the shower room." On 05/09/19 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated that during report, the CNAs are given the combination to the lock on the shower room door and remind staff that no one can be left alone in the shower room. On 05/09/19 at 10:45 AM, the surveyor interviewed the Unit Manager (UM). The UM stated that she will make the assignment for the CNAs and give them report concerning resident care and how much assistance each resident needs. The UM further stated that the CNA assignment will designate which residents should be showered during the shift. The UM stated that she had given Resident #91 a shower and the	F 689		

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F 689	Continued From page 19	F 689		

resident required the assistance of one person. The UM stated that the resident should "never be left alone."

On 05/09/19 at 10:51 AM, the Administrator provided the surveyor with a copy of the undated "CNA 5 Man Schedule Shift 7-3," which reflected that the Agency CNA was assigned to Resident #91. The surveyor further noted that Resident #91 was not scheduled to be showered during this shift.

On 05/09/19 at 11:28 AM, the surveyor interviewed the Regional Director. The Regional Director was unable to provide education provided to the Agency CNA.

On 05/09/19 at 11:32 AM, the surveyor interviewed the RN. The RN confirmed he remembered the incident on 04/23/19. The RN stated that when he interviewed Resident #91, the resident would not tell the RN who unlocked the door and left the resident in the shower room. The RN stated that CNA education is given at the change of shift with report. The RN stated the UM will make the CNA assignment and tells the CNAs about the resident's level of care and who receives a shower. The RN indicated that it is his responsibility to oversee the care of each resident and to make sure a resident is showered. The RN confirmed that education was given on orientation not to leave a resident alone. The RN said, "I was absolutely informed of it." The RN noted that he will "remind" staff not to leave a resident alone in the shower room.

On 05/09/19 at 11:53 AM, the surveyor interviewed the Agency CNA who stated she let the resident into the shower room and that she

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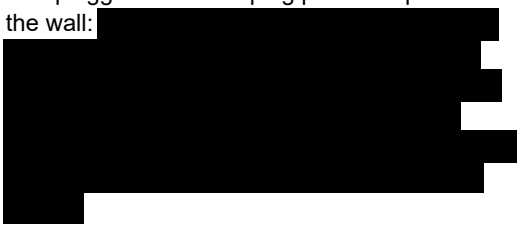
left the resident unattended. The Agency CNA further stated that it was her intention to go back and check on the resident, but she lost track of time. The Agency CNA stated that she knew better and apologized and said, "It will not happen again." The Agency CNA further stated that it was her understanding that Resident #91 did not get hurt. The Agency CNA told the surveyor that she has been coming to this facility for 15 years, received education about showers but she could not remember when.

On 05/09/19 at 1:55 PM, the surveyor interviewed the Staffing Coordinator. The Staffing Coordinator confirmed that she could not locate any education for this Agency CNA. The Staffing Coordinator further stated that the facility has only been using agency staff for a little over a year and that she will call the Agency CNA when needed.

The surveyor reviewed the facility's Shower/Tub Bath policy dated as reviewed 8/2018. The policy revealed, "Stay with the resident throughout the bath. Never leave the resident unattended in the tub or shower."

2. On 5/2/19 at 10:23 AM, in the presence of the Unit Manager (UM), the surveyor observed in Resident #24's room that the following equipment was plugged into a six-plug power strip affixed to the wall:



On 05/02/19 at 10:30 AM, the surveyor

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interviewed the Environmental Specialist (ES). The ES stated that he had to use the surge protector because it was safest for the resident and in an emergency, staff could run an extension cord out to the emergency plug located outside the resident's room in the hallway. He further stated that he knew it was not supposed to be that way as the Life Safety Regulation required that this type of equipment must be plugged directly into the wall, but he didn't think that was best for the resident.

On 05/03/19 at 10:33 AM, the surveyor observed that the aforementioned six-plug power strip was removed from Resident #24's wall and was replaced with a new six-plug power strip. The resident's [redacted] was plugged into the power strip.

On 05/06/19 at 09:04 AM, in the presence of the UM, the surveyor observed that both Resident #24's [redacted] were plugged into the six-plug power strip.

On 05/07/19 at 09:15 AM, the surveyor observed that Resident #24's [redacted] was unplugged, and the cord was lying on the floor. The six-plug power strip did not have anything plugged into it.

On 05/07/19 at 2:41 PM, the surveyor interviewed the Administrator who stated that he didn't know why a power strip was in use in Resident #24's room. He further stated that he made sure that there was nothing plugged into the power strip today because there were plenty of other sockets available and it wasn't necessary. He stated that the power strip would be removed that day.

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F 689	Continued From page 22 NJAC 8:39-27.1(a) NJAC 8:39-31.7(g)	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) [redacted]. The facility must ensure that residents who require [redacted] receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a maintain ongoing records of communication with the [redacted] facility for 3 residents (Resident #13, #33 and #70). This deficient practice was identified for 3 of 3 residents reviewed for [redacted]. This deficient practice was evidenced by the following: 1. On 5/6/19 at 10:35 AM, Unit Manager (UM) #2 provided the surveyor with Resident #13's [redacted] Communication Book which contained Communication Forms (Form) for the period of April and May 2019. A review of the initial Form contained within the book was dated 04/22/19. The Form was divided into three sections. The first section was completed by the sending facility nurse who was required to provide the following information related to resident status: time, blood pressure, meal provided, medications given in past 12 hours, [redacted] access location and condition, any concerns or changes in treatment (new medications, [redacted]	F 698	F-689 1. resident #13,#33 and #70 [redacted] communication books are being completed by the facility nurse and the [redacted] center. 2. All [redacted] residents have the potential to be affected when [redacted] Communication books are not completed. 3. An in-service was done with the nurses by the Director of Nurses on the completion of [redacted] forms upon return from the [redacted] center. The Nurses were also in-serviced to call the [redacted] center if the communication form is not completed in its entirety by the [redacted] center of if the communication form does not return with the resident. 4. The Director of Nurses, Assistant Director of Nurse, Unit Managers and nursing supervisior will ensure the [redacted] communication forms are completed and	6/12/19

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F 698	Continued From page 23 [redacted] etc., followed by the nurses signature and date. The second portion of the Form was completed by the [redacted] nurse who was required to document [redacted] weights and [redacted] weights, issues or concerns with treatment, medications provided while on [redacted] new medications ordered, followed by nurse's signature and date. The third portion of the Form was required to be completed by nursing upon resident return to the facility and detailed the time of return, condition of [redacted], nursing signature and date. On 05/06/19 at 11:08 AM, the surveyor reviewed the contents of Resident #13's [redacted] Communication Book with UM #2 and remarked that the book failed to contain [redacted] Communication Forms for 04/09/19 and 04/23/19. The surveyor then reviewed the Nurse's Notes for the dates which did not detail any information that pertained to [redacted] treatment. On 05/06/19 at 12:14 PM in a later interview, the UM stated that she was unable to locate the missing [redacted] Communication Forms for 04/09/19 or 04/23/19. The surveyor continued to review Resident #13's [redacted] Communication Book and noted that on 04/11/19 the [redacted] center failed to document a [redacted] resident weight and upon resident return to the facility, the receiving nurse signed and dated the form and left the remainder of the required fields blank. The surveyor observed that on the following dates the lower portion of the form to be completed by the receiving facility nurse was left blank: 04/02/19, 04/04/19, 04/16/19, 04/18/19, 04/25/19,	F 698	returned with the resident each day they receive [redacted], x 60 days. The DON and the Assistant Director of Nurses will then check weekly x 60 days. All findings will be reported at the Quality Assurance meeting x 2 quarters.	

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F 698	Continued From page 24 04/27/19, and 05/02/19. Review of the Form, dated 05/07/19, revealed that the [redacted] nurse provided the [redacted] weight and [redacted] weight but failed to complete the remainder of the form or sign and date the entry. On 05/07/19 at 12:20 PM, the surveyor interviewed UM #2 who stated that either the UM or the Assistant Director of Nursing was responsible to review the [redacted] Communication Book to ensure that it was completed as required. She further stated that there had been a lot of turnover at the facility and she was not sure who was supposed to review it now. UM #2 added that she would expect the receiving nurse to phone the [redacted] center to obtain any missing documentation such as [redacted]s weights and document the outcome of the phone call within the Nurses Notes. A review of the Nurses Notes from 04/02/19 to 05/02/19 revealed that there was no documentation to reflect that the [redacted] center was contacted regarding missed information on the Forms. 2. On 05/06/19 at 01:01 PM, the surveyor interviewed Resident #33. The resident stated he/she went to [redacted] three times a week with a staff member on Tuesday, Thursday and Saturday. According to the medical record, Resident #33 had a diagnosis of [redacted] and received [redacted] on Tuesday, Thursday and Saturday.	F 698		

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	315124	A. BUILDING _____ B. WING _____	05/09/2019

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F 698	Continued From page 25 On 05/03/19 at 01:53 PM, the surveyor interviewed the Licensed Practical Nurse. The LPN confirmed the resident went to [redacted] three times per week with a pick up time of 9:30 AM. The LPN stated that the [redacted] Communication Form is sent with the resident with each [redacted] visit. The LPN noted it was the responsibility of the facility nurse to complete the top portion of the form titled "To be completed by the facility nurse," the [redacted] nurse completed the middle section of the form titled "To be completed by the [redacted] Unit," and the facility nurse completed the bottom portion of the form titled "To be completed upon return to the facility" when the resident returned from [redacted] On 05/03/19 at 1:59 PM, the surveyor interviewed the Unit Manager #1 (UM). UM #1 stated that the [redacted] Communication Book was left at the [redacted] center with the resident's last visit and she contacted the [redacted] center. On 05/06/19 at 09:01 AM, UM #1 provided the [redacted] Communication Book for Resident #33. The surveyor reviewed the Dialysis Communication Book from April 1 through May 4, 2019. The [redacted] Communication Book revealed on three out of the nine days that Resident #33 went to [redacted], the [redacted] Communication Forms were missing (04/02/19, 04/06/19 and 04/23/19.) The [redacted] Communication Book further revealed that two of the nine [redacted] Communication Forms completed in April 2019 were incomplete as follows: The [redacted] nurse and the receiving facility nurse did not complete their sections on 04/04/19; and on 04/30/19, the receiving facility nurse signed and dated their section but did not complete the designated areas of "Time returned	F 698		

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F 698	Continued From page 26	F 698		

to facility," [redacted]

The surveyor reviewed the Nurse's Notes for April 2019. The Nurse's Notes did not reveal documentation when the resident returned from [redacted] on 04/02/19 and 04/30/19.

On 05/08/19 at 10:30 AM, UM #1 verified that she provided all of the [redacted] Communication Forms. UM #1 stated that she expected the form to be fully completed by the sending facility nurse, the [redacted] nurse and the receiving facility nurse.

3. On 05/08/19 at 08:44 AM, the surveyor interviewed Resident #70. The resident stated he/she goes to [redacted] three times a week. The resident stated that he/she takes the form to [redacted].

According to the Face Sheet, Resident #70 had a diagnosis of [redacted] and received [redacted] on Tuesday, Thursday and Saturday with a pick up time of 10:30 AM.

On 05/08/19 at 09:00 AM, the surveyor interviewed UM #2. UM #2 confirmed Resident #70 went to [redacted] on Tuesday, Thursday and Saturday with a pick up time of 10:30 AM. UM #2 provided the surveyor with the [redacted] Communication Book for Resident #70.

The surveyor reviewed the [redacted] Communication Book for Resident #70 for the month of April 2019. The [redacted] Communication Book revealed that the [redacted]

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F 698	Continued From page 27 Communication forms were missing for four out of 10 days the resident received [redacted] on 04/02/19, 04/18/19, 04/20/19, and 04/25/19. On 05/08/19 at 09:46 AM, the surveyor interviewed the LPN. The LPN stated that the [redacted] Communication Form is sent with the resident with each [redacted] visit. The LPN noted that before a resident is sent to [redacted] she checked the resident's vitals and filled out the top port of the [redacted] Communication Form. The LPN further stated the [redacted] nurse completed the middle section of the form titled "To be completed by the [redacted] Unit" and the facility nurse completed the bottom portion of the form titled "To be completed upon return to the facility" when the resident returned from dialysis. On 05/08/19 at 11:56 AM, Unit Manager #2 confirmed the following [redacted] Communicatiom forms were missing for Resident #70: 04/02/19, 04/18/19, 04/20/19 and 04/25/19. The surveyor reviewed the facility's [redacted] policy, dated 01/06/17, which revealed, "Communication with the [redacted] Center will be maintained through the use of a communication book." The policy further revealed, "The communication book is sent with the resident each time they are transported to [redacted] " and "the nursing staff and the [redacted] Center will communicate any pertinent resident information through the communication book." The policy reflected, "The communication book will be reviewed, initialed with the date and time, by the licensed nurse upon return from [redacted] ." NJAC 8:39-27.1(a)	F 698		

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F 756	Continued From page 28	F 756		
F 756 SS=B	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		6/12/19

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F 756	Continued From page 29 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to a.) complete an admission medication review for one resident (Resident #49); and b.) complete monthly medication reviews for two residents (Residents #70 and #74). This deficient practice was identified for 3 of 6 resident reviewed for unnecessary medications and was evidenced by the following: 1. According to the Face Sheet, Resident #49 was admitted to the facility on [redacted] with diagnoses that included [redacted]. The only drug regimen review in the resident's medical record was completed by the Pharmacy Consultant on 04/05/19. On 05/08/19 at 11:30 AM, the surveyor asked the Unit Manager (UM) if there were any prior medication reviews from the Consultant Pharmacist for Resident #49. The UM stated that she would look for any other documentation by the Pharmacist. The Unit Manager could not locate any further medication reviews by the Pharmacy Consultant. During a meeting with the Administrator, Regional Director and the Regional MDS Coordinator on 05/08/19 at 2:00 PM, the surveyor stated that there was only one Pharmacy Consultant drug	F 756	F-756 1. A new Director of Nurse was hired. The pharmacy company that was in place prior to the change was reinstated as the Pharmacy Consusltant Company. The pharmacy company that was in place during the survey could not provide the facility with any information on residents #49,70 and 74. and could not give a copy of their comments for March/April. 2. All residents have the potential to be affected when medication information from the pharmacy consultant have not been reviewed timely. A review of other resident charts revealed that the Pink (Pharmacy Consultant sheets) were missing. The pharmacy group came in to review cahrts for a second time. 3. An in-service was done with the new Director of Nurses to ensure that information in the medical records are not removed for review as previously done by the former Director of Nurse. The DON, ADON, and Administrator met with the previous Consulting Pharmacist and susequently hired them back. 4. The DON and ADON will ensure all residents are seen in a timely manner and will ensure follow up is timely and ongoing. All findings will be reviewed at the Quality Assurance meeting x 2	

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F 756	Continued From page 30 regimen review for Resident #49 in the resident's medical record. The surveyor explained that the resident was admitted on [redacted] and the medication review was dated more than a month after admission. The administrative and consultant staff were not able to produce any further documentation by the Pharmacy Consultant for Resident #49. 2. The surveyor reviewed Resident #70's medical record for the March and April 2019 monthly Consultant Pharmacist medication reviews. The surveyor noted that the medical record did not contain these documents. 3. The surveyor reviewed Resident #74's medical record for the March and April 2019 monthly Consultant Pharmacist medication reviews. The surveyor noted that the medical record did not contain these documents. On 05/08/19 at 10:30 AM, the UM, in the presence of the surveyor, reviewed the medical record of Resident #74. The UM could not locate the March and April 2019 Consultant Pharmacist medication reviews. The UM stated that she would ask the Regional Director about these documents for Residents #70 and #74. On 05/08/19 at 10:45 AM, the surveyor interviewed the Regional Director, the Regional MDS Coordinator and the Administrator. The Regional Director stated that a new Consultant Pharmacist started in March of this year. The Regional Director further stated that the former DON had concerns and had removed the Consultant Pharmacist's "pink" sheets from the resident's charts for review. The MDS Coordinator stated that the Consultant	F 756	quarters.	

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Pharmacist told her that she does not chart in the record if she does not have a concern. At the same time, the Administrator stated that he would call the Consultant Pharmacist to obtain her "notes."

On 05/08/19 at 11:29 AM, the surveyor interviewed the Consultant Pharmacist who confirmed she started in March 2019 with the facility. The Consultant Pharmacist stated on each visit, she obtains the census sheet from the facility and reviews each resident's medications listed on the census sheet. The Consultant Pharmacist stated she will document her remarks on a "pink" sheet and place it in each resident's file. The Consultant Pharmacist confirmed she reviewed each resident's medications for the past two months that were listed on the census sheet. The Consultant Pharmacist stated, "I am not responsible if the facility lost the pink sheets."

On 05/09/19 at 11:28 AM, the Regional Director in the presence of the surveyor, telephoned the 1st Floor UM. The UM confirmed the Consultant Pharmacist's "pink" sheets were removed by the former DON and cannot be found. The facility could not provide the surveyor with the Consultant Pharmacist's "pink" sheets completed in March and April 2019 for Residents #70 and #74.

The surveyor reviewed the Consultant Pharmacist Retainer Agreement dated 02/22/19. The Agreement revealed the Consultant Pharmacist will complete "Monthly reviews of the drug regimen of each skilled care resident; reports of any significant irregularities requiring immediate attention will be made to the nurse in charge and/or the attending physician, or facility

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F 756	Continued From page 32 administrator." The Agreement further revealed the Consultant Pharmacist will "review new and readmission orders and orders for change of status residents, when provided to Consultants for review." NJAC 8:39-29.3	F 756		