STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Manor Healthcare and Rehabilitation Center	18 W Laurel Road Stratford, NJ 08084

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41260 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain dignity during meal services for 1 of 3 residents (Resident #89) observed who required assistance with eating. This deficient practice was evidenced by the following: 1. On 04/04/24 at 12:21 PM, the surveyor observed Resident #89 being fed by a Licensed Practical Nurse (LPN) in the main dining room. The LPN stood over Resident #89 who was seated at a dining table. At 12:28 PM, the LPN walked away from Resident #89 to assist another resident. When the LPN returned to Resident #89, she sat next to the resident while she fed him/her. At 12:36 PM, the LPN stood back up and continued to feed Resident #89 while standing over the resident. During an interview with the surveyor on 04/04/24 at 12:40 PM, the LPN stated that when staff feed residents, the staff should be seated in front of the resident for better etiquette. The LPN further stated that she stood up while feeding Resident #89 because her back hurt. 2. On 04/05/24 at 12:15 PM, the surveyor observed Resident #89 sitting up in bed in his/her room. The resident's lunch tray was on an overbed table in front of the resident. The lunch tray was uncovered and set up for the resident to eat. Resident #89 was holding a stuffed animal and was not eating from the lunch tray. At 12:18 PM, the Registered Nurse/Unit Manager (RN/UM) entered Resident #89's room to assist another resident with his/her lunch. Resident #89 was still sitting up in bed with his/her lunch tray uncovered in front of him/her. At 12:28 PM, another staff member entered Resident #89's room, sat next to the resident, and began feeding him/her. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 04/05/24 at 12:37 PM, the RN/UM stated that the Certified Nursing Assistants (CNA) pass out the meal trays and know which residents require assistance with feeding from their change of shift report. The RN/UM further stated that the CNAs pass out the feeder trays last and keep the trays covered until they are ready to feed the resident. The RN/UM also stated that staff should be sitting next to the resident while feeding to promote an individualized experience and make it pleasurable for the resident. According to the Admission Record, Resident #89 had diagnoses which included, but were not limited to, dementia and Alzheimer's Disease. Review of the significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/27/24, included the resident had a Brief Interview for Mental Status score of 00, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident was on hospice services. Review of the Care Plan, revised 03/12/24, included Resident #89 was at risk for weight loss due to sporadic food and fluid intake 2nd [secondary] to dementia, with an intervention that, staff will continue to feed & encourage [Resident #89] to complete all food and fluids. During an interview with the surveyor on 04/05/24 at 1:02 PM, the Assistant Director of Nursing (ADON) stated that the CNAs pass out the meal trays, but if the resident was a feeder, the CNA would hold the tray until they were ready to feed the resident. The ADON further stated that when staff feed residents, they should be sitting at eye level to the resident for dignity reasons. During an interview with the surveyor on 04/05/24 at 1:06 PM, the Director of Nursing (DON) stated the CNAs and nurses pass out the meal trays, but will save the feeder trays until last when the staff can feed the resident. The DON further stated that staff should not leave a tray uncovered in front of a resident that staff weren't ready to feed because the food could get cold. The DON also stated that when staff feed residents, it is important for staff not to stand over the resident for the resident's dignity. When informed of the observations made by the surveyor the DON verified that the LPN should have asked another staff member to feed Resident #89 if the LPN could not tolerate sitting, and that staff should not have left Resident #89's meal tray uncovered in front of him/her if the staff were not ready to feed the resident. Review of the facility's Meal Pass policy, dated 10/2023, included, Should the resident require assistance with feeding, the resident will be assisted by a qualified staff member. The policy did not include how staff should be feeding residents. NJAC 8:39-4.1(a)12

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

33106

Complaint NJ #: 169845

Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan to address a.) fall prevention interventions and b.) pressure ulcer interventions.

This deficient practice was identified for 2 of 19 residents reviewed for resident-centered care plans (Resident #62 and #397) and was evidenced by the following:

1.) According to the Admission Record, Resident #62 was admitted to the facility with the diagnoses which included but was not limited to spinal stenosis (condition where spinal column narrows and compresses the spinal cord) and abnormality of gait and mobility. The admission Minimum Data Set (MDS) an assessment tool which facilitates resident's care dated 03/02/24, indicated that Resident #62 scored a 7 out of 10 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had moderate impairment in cognitive status.

On 04/04/24 at 12:10, the surveyor observed Resident #62 in the main dining room. The resident was unable to be interviewed due to decreased cognitive status. The resident was observed sitting in a geri-chair (reclining chair) in a reclining position at the table. The surveyor observed a chair alarm attached to the back of the chair. The surveyor asked the Licensed Practical Nurse (LPN #1) if the resident could sit in a regular chair for meals and she stated that the resident was in the reclining chair because she was identified as a high risk for falls.

The surveyor reviewed Resident #62's electronic medical record which revealed the following information:

The admission Progress Note dated 02/24/24 at 01:33 PM (13:33 hours), indicated that Resident #62 was a new admission and scored a 8 on the fall assessment which indicated that the resident was at a moderate risk for falling.

The Treatment Administration Record (TAR) dated 02/24/24, reflected a physician's order (PO) for the resident to have a bed alarm and for staff to check every shift for placement and function for safety.

The TAR also reflected a PO dated 02/24/24 for Resident #62 to have a chair alarm and for staff to check every shift for placement and function for safety.

The Occupational Therapy Discharge Summary dated 02/24/24-04/04/24 indicated that discharge recommendations included: geri-chair (reclining chair) for out of bed positioning to enable safe mobility and for fall monitoring.

The surveyor reviewed Resident #62's Care Plan (CP) which did not include documentation regarding fall interventions for the geri-chair, bed alarm or chair alarm.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/05/24 at 11:30 AM, the surveyor observed that the resident was not in her room. The surveyor observed a bed alarm attached to the bed. On 04/05/24 at 11:47 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that she had been employed in the facility for 4-5 months. The CNA described the resident as feisty and confused. She stated that the resident required total care with all aspect of activities of daily living (ADLs). She stated that the resident was incontinent and wore protective briefs for vanity and hygiene and that the resident's skin was intact. She stated that the resident was able to feed himself/herself and wore hearing aids. She continued to explain that the resident got up every day to the geri-chair and had bed alarm and chair alarm because he/she was at risk for falls and had the potential to lean forward out of the w/c. On 04/05/24 at 12:10 PM, the surveyor observed Resident #62 sleeping in the geri-chair, reclined at the table in the main dining room. On 04/05/24 at 12:54 PM, the surveyor interviewed the Director of Rehabilitation (DOR) who stated that Resident #62 was discontinued from therapy on 4/4/24. The DOR explained that Resident #62 was receiving PT for strengthening, balance, transfer training and sit to stand modalities. He stated that on admission residents were provided with a wheelchair (w/c) and evaluated to assure appropriateness (size, height, depth, and any other accessories added to the w/c). He stated that nursing would make the decision if the resident was to utilize a geri-chair. He stated that Resident #62 was utilizing a geri-chair for positioning and fall monitoring. On 04/05/24 at 01:18 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that Resident #62 utilized the geri-chair because the resident was agitated at times and was not able to ambulate by himself/herself. She stated that when the resident was up in a regular wheelchair he/she was able to get up on his/her own and had the potential to fall. She stated that the resident was evaluated by therapy and that the geri-chair was recommended. The RN/UM also added that the resident had a physician's order for a bed alarm and a chair alarm. The UM reviewed the CP in the presence of the surveyor and stated that that all fall preventions devices such as the geri-chair, bed alarm and chair alarm should be documented in the CP. The RN/UM confirmed that these devices were not implemented on the resident's CP. On 04/05/24 at 01:10 PM, the surveyor interviewed LPN #2 stated that Resident #62 was alert with confusion, took medication crushed, was a fall risk and utilized a bed alarm and chair alarm. She stated that the resident required total care with all aspects of ADLs and did not receive therapy at this time. She stated that the resident did not have a history of falls. She explained that physical therapy (PT) made the determination if the resident was appropriate for the use of a geri-chair. She stated that Resident #62 moved alot in the geri-chair and would scoots to the front of the chair which then required reminders to sit back in the chair so that he/she did not fall. She stated that when fall interventions were instituted such as a geri-chair, bed alarm and chair alarm the fall interventions should be documented in the care plan and the physicians' orders. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/24 at 09:31 AM, the surveyor interviewed the DON who stated that when a resident was admitted a fall risk assessment was completed and that the residents were evaluated by PT and occupational therapy (OT). The DON confirmed that fall prevention interventions should be put into the residents Care Plan (CP). She stated that the CP to specify what the residents fall interventions were and what goals the resident had and was also a form of communications between the interdisciplinary team. She continued to state that each Department was responsible to update the CP and this usually took place during the resident's care conference. The facility policy titled, Care-Plans Comprehensive with a revised date of 06/2023, indicated that each resident comprehensive care plan was designed to reflect treatment goals. The CP interventions were designed after careful consideration of the relationship between the resident's problem areas, their causes, resident feedback, and preferences. The policy indicated that CP revisions and assessment of resident was ongoing and CPs were revised as information about th resident and the resident's condition change. 41260 2.) On 04/04/24, the surveyor reviewed Resident #397's closed record: According to the Admission Record, Resident #397 had diagnoses which included, but were not limited to, pressure ulcer of the sacral region stage 4, protein-calorie malnutrition, diabetes mellitus, adult failure to thrive, and dementia. Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/05/23, included the resident had a Brief Interview for Mental Status score of 03, which indicated the resident's cognition was severely impaired. Further review of the MDS included the resident had one unstageable pressure ulcer that was not present upon admission to the facility. Review of a Progress Note, dated 08/18/23 and written by the wound care consultant (WCC), revealed the resident had an unstageable pressure ulcer to the sacrum. Further review of the progress note included the following preventative measures: The patient continues on an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus, and the following new recommendations: apply a pressure redistributing cushion to wheelchair when out of bed. Review of a Progress Note, dated 08/25/23 and written by the WCC, included the same preventative measures and recommendations as the 08/18/23 note. Review of a Progress Note, dated 09/14/23 and written by the WCC, included the same preventative measures as the 08/18/23 note, but included the new recommendation of a ROHO cushion (specialized wheelchair cushion) if out of bed. Review of the Order Summary Report, as of 10/20/23, did not include any physician orders for an air mattress or wheelchair cushion. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan included a focus, dated 08/18/23 with no revision date, that Resident #397 had a sacral pressure ulcer, but the interventions did not include an air mattress or wheelchair cushion. During an interview with the surveyor on 04/10/24 at 10:03 AM, the DOR stated that if a resident needed a ROHO cushion, the nursing department would put in a request to the therapy department who would provide the cushion. When asked about Resident #397, the DOR stated the resident received therapy services in September 2023 and had been given a ROHO cushion from the therapy department, but was unable to provide any related documentation. During an interview with the surveyor on 04/11/24 at 9:15 AM, CNA #2, stated she knows which residents have pressure ulcer preventative devices from the change of shift report. CNA #2 further stated that the nurses were responsible for ensuring the air mattresses and wheelchair cushions were in place and functional. CNA #2 added that the importance of air mattresses and wheelchair cushions were to help heal pressure ulcers. During an interview with the surveyor on 04/11/24 at 9:20 AM, LPN #3 stated that she knows if a resident has an air mattress or wheelchair cushion because they will be included on the resident's care plan. LPN #3 further stated that a physician's order would be obtained for an air mattress and a ROHO cushion as well. LPN #3 added that the Unit Manager updates the resident care plans and that it was important to include pressure ulcer preventative measures on the care plan because, it is part of the resident's care program and if it is not documented anywhere, it wasn't done. During an interview with the surveyor on 04/11/24 at 9:25 AM, RN/UM #2 stated she was unsure where a resident's air mattress and wheelchair cushion would be included in the resident's medical record. RN/UM #2 further stated that each department was responsible for updating the care plans and that it would be important for pressure ulcer preventative measures to be included on the care plan in order to help with the overall healing of the wound and prevent worsening of the wound. During an interview with the surveyor on 04/11/24 at 10:00 AM, the Assistant Director of Nursing (ADON) stated that the nurse would know which residents had an air mattress or ROHO cushion because it would be included in the physician's orders. The ADON further stated that the nurse was responsible for checking the placement and function of the air mattress and wheelchair cushion in order to prevent worsening of the pressure ulcer. When asked about care plans, the ADON stated the nursing department updates the care plans and that she would expect an air mattress and wheelchair cushion be included for a resident with a pressure ulcer to make everyone aware and so that everyone is doing the best practice for the resident to prevent worsening of the wound. During an interview with the surveyor on 04/11/24 at 10:30 AM, the DON stated that staff know if a resident has an air mattress or wheelchair cushion because it would be included on the resident's care plan. The DON further stated that it was important to include these interventions on the care plan to prevent worsening of the wound and to let other staff know what treatment is going on with the resident. Review of the facility's Care-Plans Comprehensive policy, revised 06/2023, included, Each resident's comprehensive care plan is designed to: . Aid in preventing or reducing declines in the resident's functional status and/or functional levels, and, Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2(i) NJAC 8:39-27.1(a)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

43308

Based on observations, interview, and review of facility documentation it was determined that the facility failed to reconcile a physician order and accurately document on the Medication Administration Record (MAR) for a resident receiving enteral feedings (artificial nutrition given through a tube placed into the stomach). This deficient practice was identified for 1 of 19 resident reviewed for professional standards of nursing practice (Resident #446).

Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.

Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.

The evidence was as followed:

On 04/03/24 at 11:00 AM, during the initial tour the surveyor observed Resident #446 lying in bed with their spouse at the bedside. At that time, the surveyor observed the resident receiving nutritional supplement administered via a tube feeding pump (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth).

The surveyor reviewed the medical record for Resident #446.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included dysphagia (difficulty swallowing), dysarthria (difficulty speaking), and gastrotomy (creation of an artificial external opening into the stomach for nutritional support).

A review of the admission Minimum Data Sheet (MDS), an assessment tool, dated 3/25/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 05 out of 15, which indicated the resident had severe cognitive impairment. A further review of the MDS in Section GG: Functional Abilities and Goals, included under eating the resident was coded an 88 (not attempted due to medical conditions or safety concerns).

A review of the April 2024 Medication Review Report revealed the following:

start date 03/21/24: NPO [nothing by mouth] diet, NPO texture, NPO consistency for dysphagia.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	start date 03/28/24: Enteral Feed order every day shift for nutrition. Document TV [total volume] infused daily once feeding completed. start date 03/19/24: HS [bedtime] snack at bedtime accept or decline. A review of the March 2024 Medication Administration Record (MAR) reflected the following: On 3/22/24, 3/23/24, 3/24/24, 3/30/24 and 3/31/24 the nurses documented the resident accepted the HS snack. On 3/20/24, 3/21/24, 3/25/24, 3/27/24, 3/28/24 and 3/29/24 the nurses documented the resident declined the HS snack. A review of the April 2024 MAR reflected the following: On 04/01/24, 04/02/24, and 04/06/24 the nurses documented the resident accepted the HS snack. On 04/03/24, 04/04/24, 04/05/24, 04/08/24 and 04/09/24 the nurses documented the resident declined the HS snack. On 04/10/24 at 12:44 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that if a resident was NPO they would not receive an HS snack. The CNA explained NPO indicated the resident was not able to receive anything by mouth. She stated she was only aware of one resident that was a tube feed and received a meal tray, but confirmed it was not Resident #446. On 04/10/24 at 01:24 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) for resident #446. The LPN stated that the resident was NPO and did not receive any meal trays. She stated that since the resident was nothing by mouth, they would not be offered an HS snack. She further stated that the resident should not have an order for an HS snack since they were NPO. At that time, the LPN reviewed the physician orders in the electronic medical record (EMR) and confirmed there was the active physician order for an HS snack. She then acknowledged that the resident should not have that order because the resident was NPO. Upon further review the LPN stated that it was ordered on 3/19/24 and entered in EMR by the evening shift 3pm to 11pm supervisor. She stated that the 7p to 7a nurse was responsible for chart reconciliation. The LPN concluded that the HS snack needed to be discontinued. On 04/10/24 at 01:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that not all residents who received enteral feeding were NPO. She explained that some residents could receive a meal tray based on their assessment. The DON then stated that if a resident had an order for NPO then they would not receive a tray because NPO was nothing by mouth. She further stated that they should not be offered any snacks or anything to drink unless they were cleared by the physician to have it. At that time, the DON reviewed the EMR which indicated the resident received enteral feeds and was NPO. She then confirmed the resident had an order for HS snack which was discontinued on today 04/10/24. She stated that the night shift 7p to 7a nurses completed the reconciliation of orders. The DON stated the facility input automatic batch orders on admission and HS snacks was one of them. She then reviewed the MAR in the presence of the surveyor and confirmed the nurses check marked that the HS snack was accepted three (3) times for April 2024. The DON acknowledged that if it the resident was NPO then they should not have had an order or been offered an HS snack. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A further review of the April 2024 MAR reflected the HS snack was discontinued on 04/10/24 after surveyor inquiry. On 04/11/24 at 11:01 AM, the DON stated that the resident never received an HS snack and that the nurses just documented something to mark if off and acknowledged it was documented incorrectly. The DON confirmed the order should have been discontinued and reconciled prior to surveyor inquiry. A review of the facility's Admission/Readmission Order Reconciliation policy, updated 08/2023, included, 1. Review the hospital records, if a physician is not present, place a call to an on-call physician for Medication Reconciliation and verification of orders with diagnosis for every medication. A review of the facility's NPO diet policy, updated 01/2024, included, 1. Nothing by mouth (NPO) status means that a resident is not allowed to consume any foods or fluids orally. A. unless otherwise indicated by the residents' healthcare provider. 2. All aspects of the residents NPO status will be documented properly in the resident's EMAR [electronic medication administration record] chart. A review of the facility's HS Snack policy, dated reviewed 10/2023, included, 1. Due to there being more than 14 hours between meals, there is an evening snack being offered to residents who qualify. N.J.A.C. 8:39-27.1 (a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41260 Complaint NJ #: 169845 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control practices and professional standards during a pressure ulcer treatment for 1 of 2 residents (Resident #447) reviewed for pressure ulcers. This deficient practice was evidenced by the following: On 04/05/24 at 1:23 PM, the surveyor observed the Licensed Practical Nurse (LPN) perform a wound care treatment on Resident #447. The LPN performed hand hygiene using alcohol-based hand rub (ABHR) and then donned gloves. She wiped down the overbed table with a disinfectant wipe, washed her hands for 40 seconds, and gathered the treatment supplies onto the overbed table, which included a tube of santyl ointment (removes damaged tissue). The LPN donned gloves, repositioned the resident, removed the old wound dressing, and removed her gloves. The LPN then donned new gloves without performing hand hygiene, cleansed the wound with normal saline solution (NSS), and removed her gloves. The LPN donned new gloves again without performing hand hygiene, soaked a gauze with NSS, dispensed the santyl ointment from the tube onto the NSS soaked gauze, and applied the gauze to the wound. The LPN then applied a border gauze dressing to cover the wound without first writing the date and time on the dressing before the application. The LPN removed her gloves, did not perform hand hygiene, grabbed a marker from her pocket, donned new gloves, and wrote the date and time on the dressing over the resident's wound. At that time, the resident groaned in pain and the LPN asked the resident if he/she wanted any pain medication. The LPN then repositioned the resident in bed, disposed of all of the treatment supplies, except for the tube of santyl, removed her gloves, and washed her hands for 20 seconds. The LPN donned gloves and took the tube of santyl ointment from the overbed table and put it back into the treatment cart. Afterwards, the LPN wiped down the overbed table with a disinfectant wipe. According to the Admission Record, Resident #447 had diagnoses which included, but were not limited to, diabetes, sepsis (severe body response to infection), and cellulitis (skin infection). Review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/27/24, included the resident had a Brief Interview for Mental Status score of 15, which indicated the resident's cognition was intact. Further review of the MDS included the resident had a Stage 4 pressure ulcer present on admission and two Unstageable pressure ulcers present on admission. Review of the Medication Review Report, dated 04/05/24, included a physician's order to Cleanse wound with NSS, apply Santyl, cover with moistened gauze, cover with border gauze, every day shift for wound care, with a start date of 03/25/24. Review of the Care Plan, revised 03/22/24, included Resident #447 had an alteration in skin related to decreased mobility with an intervention to administer treatments for skin impairment as ordered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Manor Healthcare and Rehabilitation Center	18 W Laurel Road Stratford, NJ 08084

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 04/05/24 at 1:50 PM, the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) stated that staff should be performing hand hygiene between glove use to prevent the spread of infection. The IP/ADON further stated that the nurse should not bring multidose containers, such as a tube of ointment, into a resident's room because it isn't sanitary when returned to the treatment cart. The IP/ADON explained that the nurse should dispense the amount needed for the treatment into a medicine cup to bring into the resident's room. The IP/ADON further stated that the nurse should label the wound dressing prior to applying it to the wound to prevent pushing into the wound with the pen or marker. During an interview with the surveyor on 04/05/24 at 1:58 PM, the Director of Nursing (DON) stated that the nurse should be performing hand hygiene between removing the old, dirty wound dressing and putting on the new, clean wound dressing to prevent introducing anything dirty to the wound. The DON further stated that the nurse should dispense a multidose ointment into a medicine cup to bring into the resident's room to prevent the spread of infection. The DON also stated that the nurse should label the wound dressing prior to putting it on the wound for dignity reasons. Review of the Wound Care policy, dated 12/2023, included, Perform hand hygiene, put gloves on, and remove old dressing . Wash hands thoroughly. Put a clean pair of gloves on. Follow treatment as ordered. Ensure new wound treatment has a current date and initialed. Review of the facility's Handwashing/Hand Hygiene policy, undated, included, Appropriate twenty (20) seconds hand washing with antimicrobial or non-antimicrobial soap and water must be performed under the following conditions: . After removing gloves, and, The use of gloves does not replace hand washing. NJAC 8:39-27.1(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on interview, review of medical records and review of other pertinent facility documentation it was determined that the facility failed to a.) follow the facility policy that was in place for resident identification and b.) to coduct a through/complete investigation for 1 of 4 resident reviewed for incidents and accidents (Resident #62). This deficient practice was evidenced by the following: According to the Admission Record (AR), Resident #61 was admitted to the facility with the diagnoses which included but was not limited to hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) an assessment tool which facilitates resident's care dated 02/24/24, indicated that Resident #61 had severe cognitive deficits and required partial to moderate assistance with activities of daily living. The MDS also reflected that the resident required help with functional cognition such as planning regular task such as shopping, remembering to take medications prior to current illness. According to the AR, Resident #62 was admitted to the facility with the diagnoses which included but was not limited to spinal stenosis (condition where spinal column narrows and compresses the spinal cord) and abnormality of gait and mobility. The admission MDS dated [DATE], indicated that Resident #62 scored a 7 out of 15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident had moderate impairment in cognitive status. The MDS also reflected that the resident required help with functional cognition such as planning regular task such as shopping, remembering to take medications prior to current illness. On 04/09/24 at 12:00 AM, the surveyor reviewed an Incident and Accident Report (IAR) dated 02/28/24 at 07:15 am, which indicated that Resident #62 was involved in a misidentification and transport error. The IAR indicated that Resident #62 was taken by medical transport to a medical doctor's office in error. According to the facility investigation dated 02/28/24, Resident #62 was misidentified and taken by transport to the medical doctor's office in error and was returned to the facility and assessed for injury. The investigation indicated that no injury had occurred and that family and physician were notified. There was no documentation on the investigative report which indicated how this event occurred or how this event could have happened. There was no documentation regarding how the Registered Nurse (RN) assigned to the resident on 02/28/24 from 7:00 PM- 7:00 AM, misidentified the resident and sent the resident by mistake out on transport to a medical doctor's office. The causes of this incident were not identified on the investigative report. The investigative report did not contain a statement from the Licensed Practical Nurse (LPN #1) that identified that the resident was sent to a medical doctors appointment by mistake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 09:03 AM, the surveyor interviewed the Director of Nursing (DON) regarding misidentification of Resident #62. The DON stated that Registered Nurse (RN) assigned to Resident #62 on 02/28/24 at 7:00 PM to 7:00 AM, thought that Resident #62 had an appointment offsite to a medical doctor and sent Resident #62 out to appointment by ambulance transport company. The surveyor asked the DON why the RN sent Resident #62 and how the RN could have misidentified the resident. The DON stated that she didn't know why and indicated that the nurse assigned to the resident thought that Resident #62 had the appointment. The DON stated that the transport paperwork indicated that Resident #61 (Resident #62's roommate) was supposed to go out for the appointment. The DON stated she did not ask the RN during her investigation why or how she misidentified the resident. She stated that she thought it was because the resident did not have a name band. On 04/10/24 at 09:59 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who explained the process for scheduling and transporting resident to an outside appointment. He explained that the Administrative Assistant (AA) scheduled residents outside medical doctors' appointments. He stated that the AA would notify the nurse assigned to the resident by way of a paper form or by verbal communication. He stated that the AA then scheduled the transport and confirmed the appointment with the provider. He then explained that when residents were being transported by ambulance to outside doctors appoints that the nurse should identify the resident with the name band or picture prior to being transported. He then continued to explain that cognitively impaired residents were sent with an escort because the facility wanted to ensure the residents were safe. The LNHA confirmed that Resident #62 was cognitively impaired and was sent out of the facility without an escort. The LNHA could not speak to why LPN #1 who identified Resident #62 was sent to the medical appointment by mistake was not interviewed or did not write a statement during the investigation. The LNHA confirmed that Resident #62 was sent out of the facility by mistake on 02/28/24 and he explained that after the 7:00 PM to 7:00 AM RN sent the wrong resident (Resident #62), the 7:00 AM to 7:00 PM Licensed Practical Nurse (LPN) came in and that this LPN who was very familiar with Resident #62 and Resident #61 questioned why Resident #61, who was supposed to have a neurology appointment was still in the facility and then identified that the wrong resident, Resident #62 was sent in error. The LNHA stated that transport was then notified and were asked to return the resident to the facility. When Resident #62 returned to the facility, the resident was assessed, and no injury was noted. The LNHA stated that Resident #62's family and physician were notified. The LNHA could not speak to why the LPN who identified that Resident #62 was sent to the medical appointment by mistake, was not interviewed or did not write a statement during the investigation. The LNHA then stated that he could get the statement from the LPN at this time. The LNHA did not have a response as to why the RN who sent Resident #62 instead of Resident #61, misidentified Resident #62. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 10:34 AM, the surveyor interviewed LPN #1 who worked 7:00 AM-7:00 PM on 2/28/24. The LPN stated that she came in around 7:30 AM on 02/28/24 and made rounds. She stated that she observed that both Resident #61 and Resident #62 were not in their rooms. LPN #1 then identified that the Resident #62 was sent by mistake to Resident #61's neurology appointment. She explained that at same time she identified that Resident #62 was sent to the appointment by mistake, the daughter of Resident #61 called that facility, because she was waiting at the doctor's office for resident #61, to inform the facility that they sent the wrong resident. The RP for Resident #61 notified the facility that the resident they transported to the doctor's appointment was not Resident #61. LPN #1 stated that she was not asked to write a statement regarding these events however she completed the incident report and wrote a progress note. She also stated that she assessed the resident when she returned to the facility and that the resident was fine and free from injury. She stated that the process for identification of residents was the name band and picture on the face sheet. She stated that there was also a picture on the face sheet that was included in the resident's transport paperwork. She stated that she was not aware of how the RN sent the wrong resident out of the facility. On 04/10/24 at 11:15 AM, the surveyor interviewed the Administrative Assistant (AA) who scheduled appointments for residents. She stated that she was given the orders by the charge nurse. She stated that she prepared all paper such as the resident face sheets, resident insurance information, resident consult request, resident labs, resident medication list, and resident progress notes. She stated that she then notified family or responsible party (RP) when appointment was scheduled. She stated that if the resident was cognitively impaired, the resident absolutely had to be escorted. She then stated that if no family could accompany the resident, then a CNA was required to accompany the resident. She stated that cognitively impaired resident could not go out on transport by themselves. She explained that the facility could not send someone somewhere where they could not verbally consent to treatment or answer questions regarding their medical condition. She stated that she had been scheduling resident appointment for [AGE] years and that she always made arrangements to have a cognitively impaired resident escorted to an outside physician appointment. She then stated that the face sheet that was included in the transport paperwork contained a resident picture, and that all paperwork had the residents name attached. On 04/10/24 at 11:37 AM, the surveyor interviewed Resident #62 RP who stated that she was informed immediately that her mother/father was sent by mistake to an appointment. She stated that Resident #62 was stable and suffered no untoward effects after returning to the facility. On 04/10/24 at 11:40 AM, the surveyor attempted to interview telephone interview the 7:00 PM-7:00 AM RN who misidentified resident #62 and sent the resident to Resident #61's neurology appointment. There was no answer. Left message to return the surveyor's call. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/24 at 10:22 AM, the surveyor interviewed LPN #2 who explained the facility process for identification of residents. She stated that identification was done by picture, name bracelets and asking the resident what their name was. She stated that when sending residents out of the facility to appointments, that the nurse should verify the time of the appointment and how the resident was being transported. She stated that the nurse should assure that the transport company received the transport paperwork. She stated that if the resident being transport was not coherent enough, an escort was assigned to go with them. She stated that the resident scheduling list was posted at the nursing station. She stated that it was the nurse's responsibility to check this list when they come in for their shift to assure that residents go to their appointments. She stated that the nurse would inform the assigned CNA during report who had an appointment and what time the resident was going so that the CNA could get the resident ready. She stated that if you are not familiar with the identification of a resident the nurse should check name on the resident's door, name bracelet, picture, and ask the staff and CNA to identify the resident. On 04/11/24 at 10:36 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) for the Lower [NAME] Unit. The RN/UM stated that the identification of residents should be done by resident name tag, resident picture and asking them their name. She stated that cognitive impaired residents were sent with an escort and AA would usually document on the appointment list posted at the nurse's station, the name of the individual escorting the resident. She stated that if the residents RP was meeting the resident at the MDs office it would also be documented on the appointment list. She stated that it would be important to assure an escort went out with the resident because the cognitively impaired resident could not advocate for themselves. She explained that incidents were documented in the progress notes. She stated that the DON was responsible to complete the investigation and document any interventions that were implemented. If there is an accident or incident with a resident, the assigned nurse fills out the incident report and gets statement from staff or anyone involved. The facility policy titled, Transportation Policy dated 01/2024 indicated that upon arrival the transportation company and the nurse will identify the resident going out along with the transportation staff. The undated facility policy titled, Patient Identification indicated that acceptable means to identify residents may include the following but were not limited to: -Checking the individuals name by asking if the able to verify. -Staff verification of the resident's name. -Checking the medical record number on the face sheet. -Verifying and checking date of birth, photographs which are located on the face sheet. -Checking the ID bracelet to confirm resident's identification. The facility policy dated 03/2023 titled, Incident/Accident policy and Procedure indicated that it was the policy of the facility to provide a system whereby resident incidents and accidents were reported their causes identified when possible, timely interventions were established to reduce the probability of repeated incidents. The policy alos indicated that all employees assigned to the resident involved in the incident and accident would fill out the Employee Statement Form. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1 (a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41260 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that an indwelling urinary catheter drainage bag was stored and maintained in a manner to prevent urinary tract infections for 1 of 3 residents (Resident #40) reviewed for urinary catheters. This deficient practice was evidenced by the following: On 04/04/24 at 11:53 AM, the surveyor observed Resident #40 lying in bed and the resident had a urinary catheter. The privacy cover was secured to the resident's bed, but the drainage bag was on the floor, not in the privacy cover. The drainage bag was empty and had the date 04/03/24 written on it. During an interview with the surveyor on 04/05/24 at 9:55 AM, the Certified Nursing Assistant (CNA) stated that the CNAs were responsible for emptying the urinary catheter drainage bags. The CNA further stated that the drainage bag should not touch the floor. At that time, the surveyor accompanied the CNA to Resident #40's room so the CNA could demonstrate how to empty the drainage bag. The CNA donned gloves and a gown, removed the drainage bag from the privacy cover hanging on the resident's bed, verified the drainage bag was dated 04/03/24, emptied the bag into a urinal, emptied the urinal into the toilet, and discarded her gloves and gown. The CNA then turned on the sink in the resident's bathroom to wash her hands, dispensed soap into her hands, and then lathered her hands with soap under the stream of water. During a follow-up interview with the surveyor on 04/05/24 at 10:04 AM, the CNA stated that the process for hand washing included lathering hands with soap outside of the stream of water for 20 seconds. The CNA further stated that the importance of lathering hands outside the stream of water was to remove the germs from hands because otherwise the water will wash the soap off. According to the Admission Record, Resident #40 had diagnoses which included, but were not limited to, urinary tract infection, sepsis (severe body response to infection), cystitis (bladder infection), retention of urine, and hematuria (blood in the urine). Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/02/24, included the resident had a Brief Interview for Mental Status score of 14, which indicated the resident's cognition was intact. Further review of the MDS included the resident had an indwelling catheter. Review of the Care Plan, revised 11/02/23, included Resident #40 had an indwelling urinary catheter related to urinary retention but did not include interventions on how to maintain the urinary catheter to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 04/05/24 at 10:22 AM, the Licensed Practical Nurse (LPN) stated that the CNAs were responsible for emptying the catheter drainage bags and that the drainage bag should be secured below the resident, but not touching the floor for infection control reasons. The LPN explained that if the drainage bag was on the floor, the CNA should notify the nurse to change the bag. The LPN further stated that hands should be washed by lathering hands with soap outside the stream of water in order to stop the spread of germs. During an interview with the surveyor on 04/05/24 at 10:31 AM, the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) stated that CNAs were responsible for emptying the catheter drainage bags and that drainage bags should be kept off the floor because the floor is a source of germs and not sanitary. The IP/ADON explained that if the drainage bag was on the floor, the nurse should change out the bag. The IP/ADON further stated that the process for hand washing included lathering hands with soap outside of the stream of water because otherwise you would rinse off the soap that you need to clean the skin. During an interview with the surveyor on 04/05/24 at 10:37 AM, the Director of Nursing (DON), stated the CNAs were responsible for emptying the catheter drainage bags and that the drainage bag should be kept off the floor for infection prevention reasons. The DON explained that if the drainage bag was on the floor, the staff should notify the nurse to change the bag. The DON further stated that hands should be lathered with soap outside the stream of water during hand washing otherwise the soap will wash away and you will only be rinsing with water. Review of the facility's Insertion and Removal of Indwelling Catheter policy, undated, included, Secure urinary drainage bag below the level of the bladder and KEEP OFF THE FLOOR AT ALL TIMES. Review of the facility's Care and Maintenance of Foley Drainage System policy, dated 02/2024, included, All foley drainage bags are to be kept in privacy bags when at the beside or when a resident is in a wheelchair. Review of the facility's Handwashing/Hand Hygiene policy, undated, included, Appropriate twenty (20) seconds hand washing with antimicrobial or non-antimicrobial soap and water must be performed under the following conditions: . After removing gloves. The policy further included, Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for twenty (20) seconds under a moderate stream of running water, at a comfortable temperature. Review of the Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings, guidelines, dated 01/2021, included, When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. N.J.A.C. 8:39-23.2(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 43308 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the Nursing Home Resident Care Staffing Report daily. This deficient practice was evidenced by the following: On 04/05/24 at 12:52 PM, the surveyor observed the staffing report posted at the front desk dated 04/04/24 day shift. At that time, a review of the staffing report revealed 04/04/24 evening shift, 04/04/24 night shift, and 04/05/24 day shift was not posted. On 04/10/24 at 10:10 AM, the surveyor observed the staffing report posted at the front desk dated 04/09/24 night shift. At that time, a review of the staffing report revealed 04/10/24 day shift was not posted. On 04/11/24 at 10:40 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she was responsible for posting the daily staffing report. She explained she edited it every day and for the weekend she printed them out to be posted. The SC stated that the staffing report was kept at a table across from the front receptionist desk. She further stated that every morning she came in and ensured the posting was updated daily because it included the census, the number of nurses and the number of aides per shift. The SC concluded the staffing report should be updated and posted daily. On 04/11/24 at 12:46 PM, the Licensed Nursing Home Administrator (LNHA) stated in the presence of the Director of Nursing (DON) and survey team that staffing was post in front of the receptionist desk by the state survey book and that it was updated daily. The LNHA stated that the staffing report reflected all three shifts, and that the SC was responsible for updating it. He further stated if the SC did not then the nursing supervisors would also update it. The LNHA stated that the staffing report included, the census and the actual ratio of nursing and aides during that day. A review of the facility's undated Posting of Nursing Ratios policy, included, 2. The proper rations will be updated daily for each shift. NJAC 8:39-41.2

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49707 Complaint #: NJ171256 Based on observation, interview, record review and pertinent facility documents, it was determined that the facility failed to ensure the accountability of controlled substance inventories were completed in accordance with the facility's policy. This deficient practice was identified on 2 of 5 medication carts reviewed (Lower [NAME] medication cart #3 and Redwood medication cart #2) during the medication storage and labeling task. The evidence was as followed: On 04/04/2024 at 10:51 AM, during an interview with the surveyor, Licensed Practical Nurse (LPN #1) stated that when the pharmacy brought in the controlled substances (drug or other substance that is tightly controlled by the government because it may be abused or cause addiction), both the incoming and outgoing nurses should sign the Controlled Substance Inventory Record (CSIR) and count the actual medication cards. LPN # 1 also confirmed that the CSIR should not be missing any documentation signatures. At that time, the surveyor, in the presence of LPN # 1, reviewed the Lower [NAME] medication cart #3 document titled, Controlled Substance Inventory Record which revealed the following: On 04/03/2024 in the section labeled, 7PM OUT: there was no signature. On 04/04/2024 at 12:08 PM, in the presence of the surveyor, LPN #2 counted the controlled substances in the Redwood medication cart #2. At that time, the surveyor compared the nurses audible count to the document titled, Individual Patient Controlled Substance Administration Record - 90 Dose specifically for the medication called Tramadol HCL 50 milligrams (mg) tablets (a medication used to treat pain). At that time, LPN #2 counted 74 tablets of Tramadol. The Individual Patient Controlled Substance Administration Record - 90 Dose document revealed a count of 75 tablets of Tramadol. LPN #2 then stated she administered the Tramadol tablet to a resident but forgot to sign the Individual Patient Controlled Substance Administration Record - 90 Dose document. On the same date and time, the surveyor compared the nurse's count to the document titled, Individual Patient Controlled Substance Administration Record - 60 Dose for Pregabalin capsule 75mg (medication used to treat nerve and muscle pain). At that time, LPN #2 counted 51 capsules. The Individual Patient Controlled Substance Administration Record - 60 Dose document revealed a count of 52 capsules of Pregabalin. LPN # 3 then stated she administered the Pregabalin capsule to a resident but forgot to sign the Individual Patient Controlled Substance Administration Record - 60 Dose document. On 04/05/2024 at 09:37 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the unit manager and herself monitored the controlled substances. She further stated the purpose was to ensure it was being done and the counts were correct with no missing items. The DON confirmed the nurses should have signed the declining inventory logs as soon as the medication was dispensed. The DON acknowledged that the controlled substance inventory documents should not be missing signatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Laurel Manor Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18 W Laurel Road Stratford, NJ 08084	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the of the facility's policy dated 01/2024 titled, Narcotic and Controlled Substance Policy and Procedure under the subsection, Procedure revealed but was not limited to, 3. A Narcotic Count will be completed by two Licensed Nurses prior to the end of each shift, opening of a unit and closing of a unit. Further, the policy revealed under the section titled, Narcotic Administration that the nurse will, 4. Sign out the Narcotic from the declining sheet in the Narcotic Book immediately after taking out of the card. N.J.A.C. 8:39-29.77(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER: Laurel Manor Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 18 W Laurel Road Stratford, NJ 08084	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43308 Complaint #: NJ169880 and 170054 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to accurately document in the medical records. This deficient practice was identified for 1 of 22 residents (Resident #398) medical records reviewed and was evidenced by the following: The surveyor reviewed the medical record for Resident #398. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included muscle weakness, difficulty in walking, and cerebral infraction (stroke). A review of the care plan date initiated 11/14/23, reflected a focus of at risk for falls r/t [related to] deconditioning recent hospitalization . 12/2/23 observed on the bathroom floor near wheelchair. Interventions dated 12/2/23, included neurological (neuro) checks post fall, monitor for pain, and Xray to thoracic spine (upper and middle part of back) r/t bruising that evolved after the fall (negative). A review of the Incident/Accident Report revealed the resident had an unwitnessed fall on 12/2/23 at 5:55 PM and was found sitting on the floor in the bathroom, next to their wheelchair. It further indicated the POA was notified at 6:17 PM. A review of the Progress Notes (PN) from December 2023, revealed there was no progress note in the electronic medical record (EMR) on 12/2/23 during the 7am to 7pm shift regarding the fall until 12/3/23 at 01:27 (1:27 AM), which indicated s/p [status post] fall day, no injury noted and neuro check in progress. Upon further review, the PN did not indicate the resident's representative was notified until 12/4/23 at 00:22 (12:22 AM) which reflected, during PM [night] care staff observed a bruise on the resident's back. The POA [power of attorney] and the physician was notified. On 04/10/24 at 12:55 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated Resident #398 was very quiet and was able to stand and pivot but transferred with supervision. The LPN stated that the resident had a history of falls but could only recall one fall. She explained if the resident had a fall, then staff would assess the resident and then document it in the EMR, notify the physician and the family. She further explained that they would document in the EMR as well as complete an incident report. The LPN stated that it was important to also document the fall in the EMR, so everyone was aware that the resident had a fall. She stated that they wrote PN for the next three (3) days and assessed the resident to ensure no bruises or changes occurred with the resident. The LPN stated that the family was notified of the falls because they need to know what happened to their loved ones. She further stated that the resident's representative would be notified right after the incident occurred. The LPN stated that if there was no answer then they would leave a message for the family representative to call back and if it was more than an hour with no call back then they would attempt to call again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Laurel Manor Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18 W Laurel Road Stratford, NJ 08084	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/10/24 at 01:43 PM, the surveyor interviewed the Director of Nursing (DON) who stated that there should be a PN included with the incident report. She stated that if you don't document and the paperwork was lost no one would know what was done. She further stated that the PN showed others what was done for that resident. The DON acknowledged the nurses should have written a progress note on 12/2/23 regarding the fall in the EMR. She further acknowledged the nurses should have documented in the PN that family was notified on 12/2/23 in the EMR. The DON emphasized it should be automatic because staff should notify the resident's representative after the resident was assessed. On 04/12/24 at 09:04 AM, in the presence of the survey team both the Licensed Nursing Home Administrator (LNHA) and the DON acknowledged there should have been a progress note associated with the incident report in the EMR. A review of the facility's Incident/Accident Policy and Procedure dated reviewed 03/2023, included, The nurse also informs the responsible party immediately of any injury that may require residents to be transferred from this facility. A review of the facility's Notification of Change policy updated 01/2024, included, notify the resident's legal representative or an interested family member of the following changes. 1. An accident involving the resident which results in injury and has the potential for requiring physician intervention. A review of the facility's Nursing Documentation policy date reviewed 1/2024, included, 1. Gather information and prepare to chart, it is your responsibility as the professional or long term care staff member to document what you found, what you did or did not do for the resident. 5. Proper nursing documentation provides evidence that the nurse has acted as required or ordered. 10. When notifying MD [medical doctor] or family, include name of who you spoke to and the time. 13. Document all events including falls . in [EMR]; 14. Document your assessment post event includes interactions and any resulting actions taken to care for the resident. NJAC 8:39-35.2 (d)