STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER: Mohawk Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE: 1 O'Brien Lane Lafayette, NJ 07848	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46889 Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 1 (one) of 25 residents (Resident #46) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: On 11/12/24, at 9:30 AM and 1:32 PM, the same day, the surveyor observed Resident #46 lying in bed, awake and alert. The surveyor observed that the call bell was behind the resident's headboard, between the wall and the bed. On 11/12/24, at 1:35 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) and the LPN/Supervisor, who stated that the call bell should be within the residents' reach. The LPN placed the call bell next to the resident's right hand. On 11/13/24 at 9:27 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #46, which revealed the following: According to the Admission Record (an admission summary) (AR), Resident #46 was admitted to the facility with diagnoses that included but were not limited to unspecified dementia (memory loss), unspecified severity, with other behavioral disturbance. A review of the recent quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care dated 9/24/24, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident had asevere impairment cognition. Further review of QMDS, reflected in section GG, revealed that the resident depends on staff assistance for daily living activities. A review of the comprehensive Care Plan dated 1/17/24 included a focus area: the resident is at risk for falls due to poor safety awareness. Interventions included, but were not limited to, keeping the call bell within reach. On 11/15/24 at 11:36 AM, the team of surveyors met with the Licensed Nursing Home Administration (LNHA) and interim Director of Nursing (DON). The interim DON acknowledged that the call bell should be placed within the resident's reach. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure titled Resident Call Bells was updated on 11/2024, given by the interim DON. It states under Policy: 2. The call bell must be placed within reach of the resident. Procedure: 7. Staff will ensure that the call bell is within the resident's reach before leaving the room. NJAC 8:39-31.8(c)9

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents' bathing choice of a day shower was provided for 1 of 1 resident (Resident #83) reviewed for choices. This deficient practice was evidenced as follows: On 11/12/24 at 10:38 AM, the surveyor interviewed Resident #83 in their room. The resident stated, I am supposed to and want to get two showers per week, but I have not received a shower in weeks. A review of Resident #83's Admission Record reflected that the resident had diagnoses that included but were not limited to; major depression (persist depressed mood), type 2 diabetes mellitus(elevated blood sugar), and bipolar disorder(mood disorder with mood swings). A review of the Annual Minimum Data Set (MDS) dated [DATE], an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated that the resident had a moderately impaired cognition. Further review of the MDS indicated that the resident required setup assistance with bathing. A review of the Order Summary Report did not reflect any physician's order (PO) for showers twice per week. On 11/14/24 at 10:20 AM, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN#1) who stated all residents would receive showers twice a week on both 7-3 and 3-11 shifts. LPN#1 further stated that there are no PO for showers and all information regarding days, times, and record for showers are kept in a notebook at the nursing station. The surveyor reviewed the shower logbook which revealed, Resident # 83's showers are scheduled for Tuesday and Friday during the day shift. Further review of the shower log revealed that Resident #83 received 2 out of 11 scheduled showers from 10/1/24 through 11/14/24. LPN #1 stated they were not aware that Resident #83 had not been consistently receiving their showers as scheduled. On 11/14/24 at 10:30 AM, the surveyor interviewed the Certified Nursing Assistant (CNA#1) who stated all resident are supposed to receive showers twice per week and all information regarding resident showers are kept in the shower notebook at the nursing station. A review of the policy titled Ensuring Residents Choices with a revision date of 4/2024 revealed, It shall be the policy of [NAME] Meadows to ensure that the residents residing at our facility make their own choices which will help improve the autonomy and their mental well-being. Under the procedure section of the policy it states, 1. Prioritize and honor resident choice. On 11/18/24 at 1:08 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), interim Director of Nursing (DON), and Assistant LNHA (ALNHA) were made aware of the surveyors concerns. No further comments were provide. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:30 AM, the team of surveyor met with the LNHA, interim DON, and ALNHA and no further information was provided regarding the resident showers. NJAC 8:39-4.1(a) 3,12

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 51226 Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident was free from a physical restraint (means of limiting or obstructing the freedom of a person's bodily movement). This deficient practice was identified in 1 of 2 residents reviewed for restraints, (Residents #99) and was evidenced by the following: On 11/12/24 at 10:20 AM, the surveyor observed Resident #99 awake and was seated in their wheelchair that had a seatbelt device around the resident's waist. The resident was unable to respond to the surveyors' inquiry. The surveyor further observed that Resident #99 had contractions (abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching) to bilateral arms. The surveyor in the presence of the Licensed Practical Nurse #1 (LPN #1) assessed Resident #99. LPN #1 acknowledged to the surveyor that the resident was wearing a seatbelt for safety and to prevent the resident from falling. On 11/13/24 at 11:49 PM, the surveyor interviewed the Registered Nurse who acknowledged that Resident #99 should not be wearing the seatbelt device. A review of the Admission Record revealed that Resident #99 was admitted to the facility with diagnosis that included but not limited to Cerebral Palsy (movement disorders that originates in the brain). A review of Resident #99's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate management of care, dated 8/14/24, reflected that the resident's Brief Interview for Mental Status was not completed due to memory problem. A review of the November 2024 Order Summary Report did not reflect a physician's order for the use of seatbelt or restraint. A review of Resident #99's comprehensive Interdisciplinary Care Plan (CP) did not reflect the use of seatbelt or any restraint On 11/13/24 at 12:45 PM, the surveyor interviewed the facility's Licensed Nursing Home Administrator (LNHA) who stated there was no documentation to determine why the seatbelt was used by the resident. On 11/14/24 at 1:30 PM, the survey team met with the facility's LNHA, Director of Nursing and Administrative Assistant to discuss the above concerns. There was no further information provided. A review of the facility's policy titled, Restraint dated 01/25/23 revealed under Policy II. The Facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. The Facility will ensure that restraints will not be imposed for purposes of discipline or convenience. Further review of the policy under X. B. The Attending Physician must be notified of such use and the reason for the order. C. Orders for emergency restraints may be received by telephone. (continued on next page)

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	315044	A. Building B. Wing	11/19/2024

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-4.1(6)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39399 Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to a. ensure reference checks (RC) were completed to seven (7) out of ten (10) newly hired staff (NHS) b. ensure criminal background checks (CBC) were completed to four (4) out of ten (10) NHS and c. ensure a physical examination (PE) was performed to 2 (two) out of ten (10) NHS prior to their start date of employment. This deficient practice was evidenced by the following: The surveyor reviewed ten randomly selected new employee files. The review for reference checks for five of the eight new employees revealed the following: -Staff #1's file, a Business Office Manager who was hired on 9/23/24, revealed no RC in their file. -Staff #2's file, a Maintenance Director (MD) who was hired on 5/28/24, revealed no RC in their file. Further review of Staff #2's did not reveal that a PE was completed prior to date of hire. - Staff #3's file, a Registered Nurse #1 (RN #1) who was hired on 5/28/24, revealed no RC in their file. Further review of Staff #3's file revealed no PE completed by a physician prior to date of hire. - Staff #4's file, a Certified Nursing Assistant (CNA #1), who was hired on 8/28/24, revealed no RC in their file. - Staff #5's file, a RN #2, who was hired on 11/15/23, revealed no CBC completed prior to date of hire. - Staff #6's file, a Physical Therapist, who was hired on 1/9/24, revealed no CBC completed prior to date of hire. - Staff #7's file, a dietary aide, who was hired on 10/21/23, revealed only 1 RC in their file. Further review of Staff #7's file revealed that a CDC was not completed prior to date of hire. - Staff #8's file, a porter, who was hired on 4/23/24, revealed no RC in their file. - Staff #9's file, a CNA #2 who was hired on 9/29/23, revealed no RC in their file. Further review of Staff #9's file revealed that a CDC was not completed prior to date of hire. On 11/18/24 at 12:19 PM, the surveyor interviewed the facility's Human Resources Director who confirmed that the above employees did not have a completed reference verification and/or criminical background check prior to their date of hires. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 1:08 PM, the surveyor informed the Licensed Nursing Home Administrator, Director of Nursing, and Administrative Assistant regarding the above concern. There was no additional information provided by the facility. The surveyor reviewed the facility's policy titled Hiring Process dated 10/2024 revealed under Procedure, C. All new applicants before hire will be subject to criminal background investigation (CBI), with their authorization, to determine whether they have been convicted of a felony within the last five (5) years. Reference checks will be made for all applicants prior to employment. All new licensed personnel and licensed nursing personnel will complete a criminal background check. Under II. New Hire A. Prior to the first day of employment, the prospective employee is seen by the employee health nurse. B. The new hire will also obtain a physical examination by employee health physician or advanced nurse practitioner. N.J.A.C. 8:39-9.3 (a), (b)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on observation, interview, record review, it was determined that the facility failed to ensure a resident received a medication according to the physician's order (PO) that was indicated for breast cancer (CA) (a disease in which body cells grow uncontrollably and spread to other parts of the body) in accordance with professional standards of practice and facility policies and procedures for one (1) of 25 residents, (Resident #131), reviewed for medication administration. This deficient practice was evidenced by the following: On 11/14/24 at 8:45 AM, during the medication administration observation with Licensed Practical Nurse (LPN #2), the surveyor observed Resident #131 in their room seated in a wheelchair. LPN #2 prepared the eight (8) medications for Resident #131 and stated that one of the medications was Abemaciclib which was indicated for the resident's diagnosis of breast CA were not available because the facility's pharmacy had not yet delivered the medication. On 11/14/24 at 9:20 AM, the surveyor interviewed Resident #131, who stated that they had not received the Abemaciclib since they were admitted to the facility on [DATE]. On 11/14/24 at 9:26 AM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident #131, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #131 was admitted with diagnoses that included but were not limited to malignant (a term used to describe cancer), neoplasm (abnormal and excessive growth of tissue) of an unspecified site of the left breast. A review of the November 2024 Order Summary Report revealed a PO dated 11/12/24 for Abemaciclib oral tablet 100 mg, one tablet by mouth twice daily for breast CA. A review of the Progress Notes dated 11/14/24 at 12:30 PM, revealed the facility's pharmacy was aware of the PO for the medication Abemaciclib. The physician was also made aware. On 11/15/24 at 11:45 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Interim Director of Nursing (I/DON) and Administrative Assistant (AA). The interim DON stated that the Abemaciclib was unavailable at pharmacy where they faxed the PO but was referred to another pharmacy who had the medication in stock. The interim DON also stated that the facility was expecting to receive the medication on 11/15/24. On 11/15/24 at 12:10 PM, the surveyor interviewed the pharmacy's customer service agent over the phone, who stated that on 11/12/24 at 11:24 PM, they received the prescription for Abemaciclib. On 11/13/24 at 11:33 AM, the pharmacy informed the facility that they did not have the medication Abemaciclib and were subsequently referred to another pharmacy. On 11/18/24 at 10:07 AM, the survey team interviewed Resident #13 Medical Doctor (MD) who stated he was made aware on 11/14/24 that the resident had not received five doses of Abemaciclib. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 10:40 AM, the survey team met with the LNHA, I/DON and AA. The I/DON presented the packing slip from the pharmacy which revealed that the Abemaciclib medication had an estimated shipped date of 11/14/24. The I/DON further stated the medication was received on 11/15/24. A review of the facility policy titled, Physician Orders indicated under Policy: Nursing Department will verify that physician orders are complete, accurate, and clarified as necessary and that residents receive their medication timely. 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. 44605 Based on observation, interview and record review, it was determined that the facility failed to record and document the urinary output of resident's with an indwelling urinary catheters per Physician Orders (PO). This deficient practice was noted in 1 of 2 resident's reviewed with an indwelling urinary catheter (Resident #68). This deficient practice was evidenced by the following: On 11/12/24 at 10:18 AM, the surveyor observed Resident #68 awake in their bed. Resident stated they have a catheter for urinary problems. The resident had a urinary privacy bag on side of their bed. The surveyor reviewed Resident #68's hybrid (combination of paper and electronic) medical records. The resident was admitted to the facility with diagnoses that included but were not limited to, urinary tract infection (an infection in any part of the urinary system), sepsis (body's reaction to an infection), and retention of urine (a condition where the bladder does not fully empty). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score 3 out of 15 that indicated the resident had severe cognitive impairment. A review of the active PO revealed a PO dated 10/2/24, to record the residents urinary catheter output. A review of the Treatment Administration Record (TAR) revealed the urinary catheter output was last recorded on 10/2/24. On 11/13/24 at 10:53 AM, the surveyor interviewed Licensed Practical Nurse (LPN#2), who is the regular day shift nurse for Resident #83. LPN#2 reviewed the PO for the resident and stated they did not see any recorded urinary output in the electronic or paper chart. LPN#2 further stated that the PO had been entered incorrectly. On 11/15/24 at 9:24 AM, the interim Director of Nursing (DON) provided the surveyor with facility policy titled Foley Catheter with a revised date of 2/1/24, under the procedure section of the policy revealed, 3. Monitor resident's output. 4. Document the following in the medical record, a. amount of output. A second facility policy title, Telephone and Verbal Physicians Orders with a revised date of 2/2024 revealed, 1. When a physicians' verbal or telephone order is received, the nurse is to read back the order to the doctor before entering the order into Point Click Care (PCC) to ensure accuracy. On 11/18/24 at 1:08 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), interim DON, and Assistant LNHA (ALNHA) and were made aware of the the findings. The LNHA stated that it was a mistake. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:30 AM, the survey met with the LNHA, interim DON, and ALNHA and no further information or comments were provided. NJAC 8:39-19.4 (a)4,5,6

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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. 46049 Based on observation, interview, and record review, it was determined that the facility failed to maintain complete and readily accessible medical records. This deficient practice was identified for 1 of 28 residents reviewed (Resident # 86). This deficient practice was evidenced by the following: The surveyor reviewed the hybrid (paper and electronic) medical records of Resident #86. According to the Admission Record (a summary of important information about the resident), Resident #86 had diagnoses that included but were not limited to: dementia, schizoaffective disorder (a mental health condition with symptoms of schizophrenia and mood disorders that causes a person to experience dramatic changes in their thoughts, moods, and behaviors), and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #86 scored a 4 out of 15, which indicated the resident had severe cognitive impairment. A physician's order dated 3/20/24 documented risperidone 1 mg tablet, give 1 tablet by mouth in the evening for schizoaffective disorder. A physician's order dated 10/5/24 documented trazodone 50 mg tablet, give 1 tablet by mouth at bedtime for insomnia. A physician's order dated 4/3/24 documented escitalopram 10 mg tablet, give 1 tablet by mouth one time a day for depression. A physician's order dated 3/24/24 documented divalproex sodium ER [extended release] 500 mg tablet, give 1 tablet by mouth in the morning for mood disorder related to schizoaffective disorder. A physician's order dated 3/24/24 documented divalproex sodium oral tablet delayed release 250 mg tablet, give 3 tablets by mouth for a total of 750 mg at bedtime. A care plan with an initiation date of 3/22/22 included a focus that Resident #86 was at risk for side effects due to use of psychotropic medications. An intervention of the care plan indicated Psyche [Psychiatry] consult as needed/as scheduled. A review of physician progress notes in the hybrid medical record revealed the most recent psychiatry consult notes found in the paper chart, were from March 2024. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 11:01 AM, the surveyor interviewed the Registered Nurse Supervisor (RNS) on the unit about psychiatry consultant visits. The RNS stated the psychiatry consultant (PC) visited the facility weekly. The RNS further explained the PC would follow up with routine residents every three to six months and more frequently if needed. The RNS reviewed with the surveyor the hybrid medical records and confirmed the last PC note was in March 2024. The RNS stated she recalled the PC visiting the resident in June 2024 and could not speak why there were no notes after March 2024 in Resident #86's medical record. On 11/14/24 at 12:30 PM, the acting Director of Nursing (DON) provided the surveyor with the facility's psychiatric consult policy. A review of the facility's policy titled Psychiatric Consult dated 2024, did not address PC documentation. On 11/14/24 at 1:30 PM, the surveyor informed the License Nursing Home Administrator (LNHA), the acting DON, and the Administrative Assistant of the concern that there were no psychiatry progress notes found after March 2024. The surveyor asked how soon it was expected for the PC to have visit notes in a resident's medical records. The LNHA stated their documentation should be in the resident's medical records within three days. The facility to review and provide additional information. The surveyor requested any facility policies related to physician or consultant documentation. On 11/15/24 at 11:35 AM, the LNHA and the acting DON met with the survey team. The LNHA stated that they spoke with the PC who thought he had left his notes in Resident #86's medical record. The PC sent the notes ot the facility that were not in the resident's medical record. The LNHA further explained they reviewed with the PC the importance of their notes being in the residents' medical records. The LNHA provided the surveyor with the physician's visits policy and the notes received from the PC. A review of the PC visit notes included notes dated 5/18/24, 7/24/24, and 10/5/24 which were not found in the Resident #86's medical record during surveyor review. A review of the facility's policy titled Physician Visits and Documentation, with a reviewed date of 11/14/24 under Policy and Procedure revealed: 2. The physician must write, sign, and date progress notes at each visit. These progress notes may be done in a paper chart or electronic format per facility practices. N.J.A.C. 8:39-35.2(d)