

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  Wynwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Wynwood Drive Cinnaminson, NJ 08077	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27193</p> <p>Based on interviews, review of medical records (MRs), other facility documentation, and review of facility policy, it was determined that the facility failed to a.) protect residents from physical and sexual abuse as well as b.) ensure adequate supervision for a severely cognitively impaired resident (Resident #84) with a history of wandering, from wandering into other resident rooms, leading to physical altercations and sexual abuse involving other residents. Due to the vulnerable nature of the nursing home population, there is a potential for serious injury or serious physical or psychosocial impairment from being physically shoved by Resident #152 and Resident #94 as well as Resident #84 sexually abusing residents. This required immediate action to prevent further events of physical and sexual abuse by or to Resident #84 or other residents. This deficient practice was identified for 1 of 9 residents reviewed for abuse.</p> <p>The Immediate Jeopardy (IJ) situation began on 06/04/24, and was identified on 07/01/24. Resident #84 had a documented history of wandering into other resident rooms that began on 02/22/24.</p> <p>On 06/04/24, Resident #84 wandered into Resident #152's room. Resident #152 then shoved Resident #84 which caused Resident #84 to fall, and sustained a skin tear to the left elbow.</p> <p>On 06/28/24 at 7:30 AM, Resident #94, in the presence of the surveyor, told the Licensed Practical Nurse (LPN) that they were upset that Resident #84 wandered into their room, placed their hands under the bed sheets, and touched Resident # 94's feet and penis.</p> <p>This failure to adequately supervise a cognitively impaired resident with a known history of wandering into other resident rooms and touching other residents in an inappropriate sexual manner placed all residents at an increase risk for the likelihood of serious injury or serious physical or psychosocial harm. This resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The IJ template was provided to the Licensed Nursing Home Administrator (LHNA) on 07/01/24 at 3:44 PM. The facility submitted an acceptable Removal Plan (RP) on 07/03/24 at 12:43 PM, and was verified on-site on 07/03/24 at 12:43 PM, by the survey team.</p> <p>The removal plan indicated the facility took the following steps to prevent serious harm from occurring or recurring:</p> <p>The immediacy of the IJ was removed on 07/01/24.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 315047
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>1. Resident #84 was placed on a one to one (one staff member assigned to the one to one) on 07/01/24 at 1:45 PM and Resident #84 was discharged from the facility on 07/02/24 at approximately 5:00 PM.</p> <p>2. The facility identified that all residents have the potential to be affected. All alert and oriented residents were interviewed by the Social Worker on 07/01/24 and all remaining cognitively impaired residents had full body skin checks completed on 07/01/24 to rule out abuse that could have occurred by a resident wandering into their rooms.</p> <p>3. On 07/01/24 at 4:00 PM, the Director of Nursing and designee began in-servicing all facility staff in every department on the Abuse-Neglect-Exploitation Policy, implementing effective interventions to prevent all residents from abuse and neglect, implementing effective interventions to prevent residents who wander from entering other residents' rooms, protecting residents who wander from being abused, and implementing effective interventions after a resident abuse allegation. This in-servicing will continue until all staff that work in the center are in-serviced. Staff will be in-serviced prior to starting their assignment.</p> <p>4. The LNHA or Director of Nursing will conduct audits on all residents with wandering behaviors by direct observation, resident interviews, and staff interviews to ensure that residents who have the potential to wander into other residents' rooms have effective interventions in place to prevent them from wandering into other residents' rooms and that abuse has not occurred. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. The Nursing Home Administrator or Director of Nursing will interview five alert and oriented residents regarding abuse. These audits will be weekly for four weeks, then bi-weekly x four weeks, and then monthly x one month. Findings of all audits will be reviewed by the Quality Assurance Committee at the monthly QAPI meetings x three months.</p> <p>The evidence was as follows:</p> <p>A review of the facility's abuse, neglect, and exploitation policy, Date Implemented (Left Blank), Date Reviewed/Revised 07/12/23 included, but was not limited to: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing policies and procedures that prohibits and prevent abuse, neglect, exploitation and misappropriation of resident property . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain and mental anguish. It includes verbal abuse, physical abuse, sexual abuse, and mental abuse including abuse facilitated or enabled through use of technology . The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse., neglect, and exploitation of residents and misappropriation of resident property b. Establish policies and procedures to investigate any such allegations: c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention . 3. The facility will provide ongoing oversight and supervision of staff in order to assume that its policies are implemented as written .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>1. On 6/28/24 at 7:30 AM, in the presence of the surveyor, Resident #94 told the LPN that they were upset that [Resident #84] came into their room and touched their feet and penis. The surveyor then asked the LPN if she heard what Resident #94 had said. The LPN stated, I heard it, management was already made aware. Resident #84 resided in the adjacent room connected through a shared bathroom from Resident #94.</p> <p>On 07/01/24 at 12:29 PM, the surveyor interviewed Resident #71 who was Resident #94's roommate. Resident #71 stated, my roommate got violated by [Resident #84] last night and that the facility informed the resident that Resident #84 was allowed to wander because the resident was confused. Resident #71 further stated, we were half asleep and we are not sure of what [Resident #84] is capable of doing. Resident #71 further stated that Resident #84 had been wandering into their rooms for months and that was reported to the nurses, the Certified Nurse Aides (CNA), and the Unit Manager (UM).</p> <p>On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the UM, [Resident #84] violated me. [Resident #84] always comes into our room. [Resident #84] touched my feet and this time [Resident #84] stuck their hands in my pants and touched my penis. [Resident #84] had never touched my penis before. I told the staff a million times and nothing had been done.</p> <p>On 07/01/24 at 12:35 PM, the surveyor, along with a second surveyor, then interviewed the LPN, to whom Resident #94 reported the alleged sexual abuse on 6/28/24 at 7:30 AM, in the presence of the UM. The LPN confirmed that Resident #94 reported the allegation of sexual abuse on 6/28/24 at 7:30 AM. The LPN stated in the presence of the UM that Resident #94 informed her that Resident #84 touched Resident #94 in a [redacted derogatory word for homosexual] way. The LPN confirmed to the UM, I did not write it, that was Resident #94's perception.</p> <p>On 07/01/24 at 12:58 PM, two surveyors interviewed the UM regarding Resident #84's behavior. The UM stated that Resident #84 wandered aimlessly, and that staff would keep an eye and monitor the resident.</p> <p>Review of Resident #94's medical record revealed no documented evidence of the alleged sexual abuse by Resident #84. The surveyor interviewed the Director of Nursing (DON) who stated that she was not aware of the incident, and she stated that she arrived at that facility at 6:30 AM on 06/28/24, to start an investigation into the incident.</p> <p>On 07/01/24, the surveyor reviewed the electronic medical record (EMR) for Resident #94 which revealed:</p> <p>The Admission Summary revealed diagnoses which included but was not limited to; unspecified of severe protein caloric malnutrition, adjustment disorder with depressive mood, unspecified adrenocortical deficiency.</p> <p>The Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 4/30/24, reflected the resident had a brief interview for mental status (BIMS) score of 13 out of 15, indicating that the resident had an intact cognition. Also the MDS revealed the resident was partially independent with activities of daily living (ADLs).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- 05/26/2024 timed 22:11:51 [10:11 PM] this note revealed: The resident pacing up and down hallways, difficult to redirect. Observed eating their dinner while standing and pacing around the nurse's station. Unable to sit for any length of time. Took medication without difficulty. Staff gave resident a shower and changed clothing. Resident was observed going into other resident's rooms and touching belongings. Difficult to redirect resident from touching belongings that are not theirs.</p> <p>- Another entry with an effective Date of :06/03/2024 at 12:55:00 PM, documented an incident dated 06/02/2023 timed 20:22:20 PM [8:22 PM]: [Resident #79] seen another resident referring to [Resident #84], leaving their room, [Resident #79] said What were you doing in my room? I will knock you out and throw you out that two-story window nurse de-escalated the situation, reassured [Resident #79] that nothing was taken from their room, [Resident #79] then proceeded to walk off towards the vending machine.</p> <p>- 6/3/2024 timed 13:56 PM [1:56 PM], the nurse's notes revealed the following entry: alerted by staff, another Resident #152 shoved [Resident #84] out of their room. Attempted to de-escalate behavior with 1:1 support. 9-1-1 was called for assistance. Full body assessment completed with no injuries noted. MD [medical doctor] and family notified of incident. Resident #152 was sent to crisis for evaluation. The above note was entered in the EMR on 6/4/2024 at 12:27:23 PM.</p> <p>- 6/4/24 timed 12:27 PM, a nurse's note revealed that Resident #152 shoved Resident #84 causing Resident #84 to fall. Further review of the progress note revealed, notified by staff, resident on the floor [Resident #84] stated Resident #152 shoved me . full body assessment completed and no injuries noted. L [left] elbow skin tear noted. 0.5 x 0.5 x 0.1. first aid rendered to L [left] elbow. Neurological checks (assessment of sensory neuron and motor responses, to determine if the nervous system is impaired) wnl [within normal limit] and neuro protocol initiated .</p> <p>- The skilled nurses note dated 6/12/2024 06:36:46 revealed: [Resident #84] was saturated with urine at 12:00 AM. The resident became aggressive with aide and refused assist with change. This AM [morning], the resident was going in and out of room [ROOM NUMBER], going through room [ROOM NUMBER] bed-2's closet and moving things around. Redirection only effective at times, resident is confused and forgets, needing to be constantly redirected.</p> <p>- This nursing entry created on 6/24/2024 at 13:41:01 PM, indicated: [Resident #84] observed walking in other residents' rooms and needs to be redirected.</p> <p>The Director of Nursing documented a progress note on 6/30/24, that reflected the alleged abuse that occurred on 6/28/2024 at 6:30 AM: Notified by staff that [Resident #84] entered room [ROOM NUMBER] through a shared bathroom door and touched [Resident #94's foot]. [Resident # 94] told [Resident #84] to leave. [Resident #84] left immediately via shared bathroom door. [Resident #84] was brought to nurse's station, full body assessment completed with no injuries noted. MD [Medical Doctor] and son made aware of incident.</p> <p>The progress notes written by the DON, did not include [Resident #94's] statement, in the presence of the UM and two surveyors, that they were touched in their genital area. The DON informed the surveyor that she arrived at 6:30 AM, and interviewed [Resident # 94]. The DON did not address the statements made by Resident #94 to the UM or the LPN. The facility did not implement any interventions to protect other residents from Resident #84 from 6/28/24 through 7/1/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 07/01/24 at 8:30 AM, the surveyor interviewed the LPN who worked the 11:00 PM to 7:00 AM shift on the unit when Resident #94 reported the allegation of sexual abuse on 6/28/24. The LPN stated that she was told that Resident #84 wandered into Resident #94's room and touched their feet. She documented the incident in the EMR. The LPN stated that she was not aware of Resident #84's wandering behavior.</p> <p>On 07/01/24 at 10:10 AM, the DON provided an investigation summary (IS), dated 06/28/24. The DON confirmed the IS was completed and all of the investigative documents were attached. The IS revealed that on 6/28/24 at 6:30 AM, Resident #94 reported to the staff that Resident #84 touched their feet. The DON then informed the survey team that the incident was reported to the Department of Health (DOH). The surveyor in the presence of the survey team reviewed the IS together with the DON. At that time, the surveyor informed the DON, that Resident #94 reported the allegation of sexual abuse on 6/28/24 at 7:30 AM to the LPN with the surveyor present. Further review of the IS revealed there was no statement from the LPN included with the investigation. The event documented in the IS by the DON did not reflect the statement made by Resident #94 on 6/28/24 at 7:30 AM. The IS did not include a statement from the resident's roommate, assessed by the facility as being alert and oriented with a BIMS of 15, who confirmed that Resident #84 had been wandering into their room every day and night and touched them in an inappropriate sexual manner on 6/28/24. The facility confirmed they did not interview the roommate.</p> <p>Review of the IS conclusion indicated that Resident #84 was confused, skin assessment done, there was no injury. There was no plan put into place to prevent Resident #84 from continuing to wander into other resident rooms and touching them in an inappropriate sexual manner or protect Resident #84 from other residents.</p> <p>On 07/01/24 at 1:00 PM, during an interview with the DON regarding the alleged sexual abuse, she informed the survey team that she had been re-employed at the facility for about six months, and she identified Resident #84 as a wanderer. The surveyor then asked about the process that should have been in place to prevent Resident #84 from being abused by others and to prevent abuse by Resident #84 to other residents. The DON stated that she was aware that Resident #84 wandered in the hallway, and the plan was to redirect the resident by placing signage at the door and in the bedroom, and remove from location. The DON stated that Resident #84 was confused and just walked in the hallway. The DON also stated that she was not made aware of any inappropriate sexual behavior or wandering into other resident rooms and urinating in inappropriate places in other resident rooms. If she had been made aware, she stated she would have asked for a psychological evaluation, laboratory blood work to rule out Urinary Tract Infection. The DON stated that the 11:00 PM-7:00 AM staff did not report any behavioral concerns for Resident #84.</p> <p>On 07/01/24 at 1:13 PM, the surveyor interviewed the Activity Director (AD) regarding Resident #84's activity schedule. The AD informed the surveyor that she did not have a schedule for Resident #84. The AD added that Resident #84 would not stay still and would not participate in any activity. She further stated that she had informed the nursing department in the morning meeting.</p> <p>On 07/01/24 at 1:35 PM, the surveyor observed an unidentified staff member at the entrance door leading to Resident #84's room. Upon inquiry, the staff member informed the surveyor that she was asked to be at the door for a 1:1 observation. The staff member could not indicate what behavior she was to monitor and where the behavior would be documented.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 07/01/24 at 2:15 PM, the survey team asked for the 1:1 observation policy. The LNHA informed the survey team that the facility did not have a 1:1 policy.</p> <p>On 07/01/24 at 3:00 PM, the LNHA indicated that he was not aware of all the details of the incident that occurred on 6/28/24. He stated he was told that Resident #84 touched Resident #94' feet.</p> <p>On 07/02/24 at 9:02 AM, the surveyor observed Resident #84 in bed. A male companion was noted at the bedside. The surveyor interviewed the companion who revealed that he came in at 7:00 AM and did not get report from the 11-7 staff. The companion stated he was informed that an incident occurred yesterday.</p> <p>On 07/02/24 at 9:15 AM, the surveyor interviewed the UM who revealed that he was not made aware of the allegation of sexual abuse prior to 07/01/24. The UM added, If I had known, I will report to the administrative staff, implement abuse procedure, investigate, implement 1:1 observation, ensure all residents were safe. When asked if the LPN had received education on reporting abuse, the UM stated, I believe the staff had been educated on abuse. A review of the LPN file revealed that she had received education on abuse. The surveyor then inquired regarding the wandering behavior documented in the EMR of Resident #84. The UM stated that he was not aware that Resident #84 wandered into other residents' rooms. He was aware that Resident #84 wandered in the hallway.</p> <p>On 07/03/24 at 11:45 AM, the surveyor interviewed the LPN who wrote the progress notes dated 02/22/24. The LPN confirmed Resident #84 wandered into other resident's rooms. When asked about Resident #84's behavior of urinating in inappropriate places, the LPN stated that Resident#84 would urinate in public places rather than using a urinal or the bathroom.</p> <p>NJAC 8:39 - 4.1 (a)(5)</p>		

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NAME OF PROVIDER OR SUPPLIER  Wynwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Wynwood Drive Cinnaminson, NJ 08077	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31654</p> <p>Complaint #s NJ 163250, NJ 170219</p> <p>Based on observation, interview, record review and review of other pertinent documents, it was determined that the facility failed to ensure a thorough and complete investigation was completed to determine the causal factor of injuries of unknown origin to ensure that resident abuse or neglect had not occurred for: a) a resident (Resident #150) who was found on 12/05/23, with an infected wound that required hospitalization on [DATE], and was diagnosed with osteomyelitis, and again observed during routine wound rounds on 12/19/23, with exposed bone and required transfer to the hospital on the same day, and was diagnosed with a acute fractures of the right proximal tibia and fibular diaphyses (two long thigh bones) on 12/19/23, b) an allegation of sexual abuse by Resident #94 that was reported to the Licensed Practical Nurse on 6/28/24 at 7:30 AM, the facility did not investigate the allegation until 7/1/24, c) and for a resident who had a history of being combative with care, reported new onset pain to the right hip/leg on 04/03/23, and was diagnosed with a comminuted mildly displaced fracture at the greater trochanter of the right hip on 04/07/23. This deficient practice occurred for 3 of 3 residents reviewed for abuse (Resident # 81 and #150, Resident #94).</p> <p>The deficient practice was as follows:</p> <p>Refer to F600K, F686G</p> <p>A) On 6/28/24, the surveyor reviewed the closed electronic medical record (EMR) for Resident #150. Review of the closed record revealed that Resident #150 was admitted to the facility with diagnoses which included but were not limited to; Benign prostatic hyperplasia, dementia in other diseases classified elsewhere and failure to thrive and dementia.</p> <p>According to the Annual Minimum Data Set (MDS), an assessment tool dated 8/7/23, Resident #150 was identified as having moderate cognitive impairment. Resident #150 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #150 was totally dependent on staff for all Activities of Daily Living (ADLs).</p> <p>On 07/02/24 at 11:30 AM, the surveyor reviewed all progress notes which revealed a 10/18/23 nurse's Skin Check note indicating that Resident #150 had a skin tear at the facility on the right anterior lower leg measuring 2 centimeters (cm) x 2 cm x 0.3 cm. The right hip was noted with an abscess measuring 2 cm x 2 cm x 0.2 cm. Interventions implemented for the wound were low air loss mattress, pillows between legs and bilateral heel booties. The wound had worsened and the facility did not document anything regarding the wound condition in the EMR. There was no documentation in the EMR that indicated the physician was made aware of the condition of the wound.</p> <p>Review of the Order Summary Report dated 11/2023, reflected an order dated 11/22/23, to cleanse the wound of the right anterior lower leg topically every day shift for wound, cleanse with acetic acid, do not scrub or use excessive force, pat dry, apply honey gel to wound, apply calcium alginate cut to size of wound base, cover with a bordered foam dressing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The right hip wound had an order, dated 11/29/23, to cleanse with acetic acid, do not scrub or use excessive force, pat dry, apply honey gel to wound, apply calcium alginate cut to size of wound base cover with a bordered foam dressing. The staff initialed the Treatment Administration Record (TAR) from 12/1/23 to 12/5/23 indicating that the wound care was completed as ordered.</p> <p>On 12/05/23, at 21:15 [9:15 PM] Discharge Summary (6 days later0, for a Date of Discharge from the facility on 12/05/23 revealed Resident #150 . wound to right anterior lower leg is reclassified as Stage 4 pressure injury . . purulent drainage and edema to the periwound. Unable to debride [remove dead tissue] due to the patient being severely contractive and combative. Recommend patient be sent to hospital for possible osteomyelitis. According to nursing notes, patient was admitted for wound infection.</p> <p>The Hospital record for Resident #150 for the Emergency Department to Hospital Admission which began on 12/05/23 was obtained by the Department of Health (DOH) and revealed:</p> <p>Emergency Department (ED) Provider Note dated 12/05/23 at 11:00 PM revealed:</p> <p>-Initial Complaint:</p> <p>Patient presents with wound infection coming from rehab with a wound to RLE (right lower extremity with concern for infection + [positive] malodorous and oozing . Past medical history of dementia currently living in a nursing home with contractures patient with know wounds. Nonverbal and non-interactive. History and physical completed at the hospital upon admission on 12/5/23, revealed the following: History of failure to thrive, Parkinson disease, dementia, who presents from a Long Term Care Facility (name redacted) due to right lower leg wound with symptoms and signs of infection with need for debridement. Resident #150 was diagnosed with osteomyelitis.</p> <p>The surveyor reviewed the facility Progress notes from 12/1/23 to 12/05/23 and was unable to locate any documentation regarding the wound assessment entered by facility staff. Documentation regarding the wound was entered every Tuesday by the wound care team only.</p> <p>The hospital documentation revealed on 12/06/23, regarding the wound prior to discharge back to the facility on [DATE].</p> <p>Right Hip Pressure Injury: Active present on admission.</p> <p>wound description Full Thickness Wound.</p> <p>wound length( cm) centimeter: 2.5</p> <p>wound width (2.5 cm)</p> <p>wound depth (0.2 cm) Presure injury stage Stage 3( present on admission)</p> <p>Contributing Factors:Lower extremities contractures, urinary incontinence, decreased mobility. Bed/Mobility: 2 person assist to turn.</p> <p>Bowel/ Bladder: Condom Catheter.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interventions/ recommendations:</p> <p>Cleanse wound with Normal Saline,cover with Meplex Border small sacral foam dressing, change dressing every 3 days.</p> <p>Continue to turn and reposition every 2 hours using foam wedge to maintain side-lying position.</p> <p>The readmission History and Physical entered in the EMR by the facility physician on 12/08/23, indicated the following: Resident #150 was readmitted to LTC (Long Term Care Facility) after an acute hospitalization after presenting with right lower leg wound. Imaging revealed right tibial osteomyelitis. Resident #150 was started on an antibiotic which Resident #150 will complete on 12/15 and 12/16/23. Resident #150 was transferred back to the LTC facility in stable condition.</p> <p>On 06/28/24 at 10:30 AM, the surveyor interviewed the Unit Manager (UM) regarding the process for Resident #150's wound care as the resident was on the UM's unit. The UM stated that all preventative measures would be in place and daily rounds would also be completed to ensure preventative measures were in place. The surveyor asked about documentation related to Resident #150's wound and the UM confirmed there was no narrative documentation completed to monitor wound care and the staff would be responsible for initiating the treatment when it was applied to the wound. The UM had no additional information to provide.</p> <p>On 7/8/24 at 1:00 PM, the surveyor interviewed the wound care Nurse Practitioner (NP) via telephone who stated that during wound rounds she observed that the wound had a large amount of purulent (a symptom of infection aht oozes from a wound) drainage which was not documented or communicated to the wound team. Subsequently, the NP stated Resident #150 was then transferred to the hospital on 12/5/23, and diagnosed with Osteomyelitis (inflammation of the bone caused by infection). Resident #150 was treated with broad spectrum antibiotic,Vancomycin and Zosyn for the infection. Resident #150 returned to the facility on [DATE].</p> <p>On 07/08/24 at 1:10 PM, the Director of Nursing (DON) was interviewed regarding what were the expectations for wound care documentation for Resident #150. The DON stated upon review of Resident #150, she had not been working at the facility and there was no documentation for the wound other than what was already provided to the surveyor.</p> <p>- A Nursing Documentation Progress Note entered as a Late entry, dated 12/09/23 timed 06:12 and signed by a Licensed Practical Nurse (LPN) revealed Skin color is normal, Resident #150 is displaying the following signs and symptoms of infection; loss of appetite, fatigue, increased need for assistance with ADL's, new onset of change in level of consciousness. Resident #150 has an infection. There is heat (warmth) at the site of infection. There is redness (erythema at the site of infection.) There is swelling at the site of infection.</p> <p>There was no documented evidence that the above findings were communicated to the physician or the wound care team prior to 12/05/23.</p> <p>On 12/19/23, again during wound rounds, the wound care Nurse Practitioner identified, and documented, that Resident #150 required hospitalization because when she removed the dressing, the bone was exposed. Resident #150 was transferred to the hospital and diagnosed with fracture of the tibia and fibula.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The facility provided an incident report dated 12/19/23, with the following:</p> <p>Nursing description: Noted during wound round protruding necrotic bone to right lower extremity. Due to deterioration, order obtained to send Resident #150 to hospital for evaluation.</p> <p>Immediate action taken: Assessed by wound care team</p> <p>Obtain order to send to emergency room</p> <p>Notify responsible party of changes.</p> <p>A note from the Interdisciplinary Care Team dated 12/19/23 timed 8:09 AM, relayed the following: Met to discuss recent deterioration to wound observed during wound rounds. Resident currently on low air loss mattress, wedge in place. Turns for pressure relief and daily wound rounds. New Interventions to include sent to hospital.</p> <p>The surveyor reviewed the hospital record from the hospitalization of 12/19/23, and the following were noted:</p> <p>-Comments: Right lower extremity: Contracture with flexion at the hip and knee. Significant wound on the anterior shin with exposed bone .</p> <p>-A 12/19/23 Hospital Radiology X-Ray report revealed Acute Fractures of the right proximal tibia and fibular diaphysis [right thigh long bones], additional clinical notes revealed, now presents 12/19 from the skilled nursing facility because of bone extruding through wound, as well as hematuria ([Urinary Catheter] inserted 12/17 for urinary retention) per hospital follow up with the facility the wound dressing was changed daily and the facility had no documentation regarding bone exposure and found during weekly wound observation, orthopedic plans for a Right aka [above the knee amputation] on 12/22.</p> <p>On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the DON regarding an investigation about the wound development and related to exposed bone. The DON stated she was not at the facility and that there was nothing else to provide.</p> <p>On 07/08/23 at 9:30 AM, during a telephone interview with the Resident #150's Representative (RR), she confirmed that Resident #150's leg could not be saved, Resident #150 had an amputation and was transferred to another LTC for aftercare. The RR also stated that she was not informed of any changes in the wound or any trauma.</p> <p>On 07/08/24 at 1:30 PM, the surveyor interviewed the physician in charge of the resident care at the LTC. The physician informed the surveyor that he was aware that Resident #150 having a chronic wound. The physician stated he not informed that Resident #150's bone was protruding, nor that Resident #150 sustained any trauma at the facility prior to being informed by the hospital that Resident #150 was admitted with fractures.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>B) On 6/28/24 at 7:30 AM, the surveyor entered Resident #94's room to observe the Medication Pass Administration with the Licensed Practical Nurse. The Nurse checked the resident's arm where the glucometer device was to read the Blood sugar. The resident was irritable and informed the LPN that another resident wandered in their room while they were sleeping, touched their feet, went with their hands under the cover and touched their genital area. Resident #94 identified the perpetrator as Resident #84 who resided in the next room. The LPN was about to exit the room, the surveyor asked the LPN if she heard Resident #94's concerns. The LPN confirmed that she heard Resident #94's concerns and stated, Management was already made aware.</p> <p>The surveyor continued with the Medication Administration and observed Resident #84 in the hallway near their room.</p> <p>On 6/28/24 at 10:30 AM, the surveyor returned to the North hallway and observed Resident #94 in bed. Resident #84 was observed in their room.</p> <p>On 6/28/24 at 12:15 PM, the surveyor reviewed Resident #94's electronic medical record (EMR) and noted that the incident regarding the alleged sexual abuse was not documented. The DON informed the survey team she came in at 6:30 AM and started the investigation, there was no documentation in the clinical record regarding the alleged sexual abuse.</p> <p>On 07/01/24 at 8:30 AM, the surveyor requested the investigation for the incident of 06/28/24. The Director of Nursing informed the surveyor that the allegation was reported to the New Jersey Department of Health (DOH).</p> <p>On 07/01/24 at 10:10 AM, the DON provided the investigation. The surveyor reviewed the investigation with the DON and noted the LPN's statement was not included. The investigation did not reflect Resident #94's statement made on 6/28/24 at 7:30 AM, in the presence of the surveyor. The surveyor again asked the DON for the LPN's statement which was not included in the investigation. The DON stated that she would provide the statement later.</p> <p>On 07/01/24 at 10:30 AM, a follow-up interview in the presence of two surveyors was conducted with the LPN confirmed that Resident #94 reported being violated. She stated that Resident #94 reported that Resident #84 touched them in a homosexual way. The LPN added that was Resident #84's perception.</p> <p>On 07/01/24 at 12:30 PM, the survey team met with the LNHA and the DON and requested the investigation for the alleged sexual abuse reported to the LPN on 6/28/24 at 7:30 AM. Both indicated that they were not aware of the allegation of sexual abuse. The DON stated that she was only made aware that Resident #84 touched Resident #94's feet. She reported to the facility at 6:30 AM on 06/28/24, and started the investigation.</p> <p>A note entered by the Social Worker (SW) on 6/28/24 at 6:35 PM, revealed that the SW met with Resident #94, and Resident #94 was able to explain what had happened. There was no documentation regarding being touched inappropriately.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 07/01/24 at 1:27 PM, the surveyor interviewed the SW again regarding the allegation of sexual abuse by Resident #94. The surveyor, in the presence of the survey team, asked if the SW was aware. The SW stated, just now, she was made aware of it. The surveyor asked if the SW spoke with the nurse who heard the allegation and the SW stated she was not told about the nurse who overheard the allegation of inappropriate touching unit today. The surveyor asked if the SW interviewed Resident #94 and she stated, not yet. The surveyor asked if the allegation was considered abuse and the SW stated, it is abuse and the surveyor asked why? The SW stated, if somebody touches you without your consent that is abuse, and stated, there are many types of abuse, and confirmed that Resident #84 wandered.</p> <p>On 7/01/24 at 1:30 PM, the surveyor reviewed the facility's policy on abuse, neglect and misappropriation.</p> <p>Under Reporting/ Response:</p> <p>The facility will have written procedure that include:</p> <p>Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement applicable) within specified timeframe:</p> <p>a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or</p> <p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Assuring that reporters are free from retaliation or reprisal;</p> <p>Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime., This facility will post a conspicuous notice of employee rights including the right to file a complaint with the State Survey Agency if the employee believe the facility has retaliated against him/her for reporting a suspected crime and how to file a complaint.</p> <p>The administrator will follow up with government agencies during business hours, to confirm the initial report was received, and to report results of the investigation when final within 5 working days of the incident, as required by state agencies.</p> <p>C) A Reportable Event Record/Report (RER) was received by the Department of Health (DOH) on 04/06/2023 regarding Resident #81 which revealed: Date of Event: 04/06/2023, Time of Event: 11:10 AM. 1. Narrative: At 11:10 AM on 04/06/23, notified that a 3 cm (centimeter) linear bruise noted to R (right) hip on Monday 04/04/2023. Resident has advanced stage dementia and does not speak English. Resident does ambulate without assistance at times in room. Resident has a Dx. (diagnosis) osteopenia and osteoarthritis. 3. Resident was assessed for further injuries and no further injuries were noted. X-rays were completed for R hip, R femur, and R knee and were negative for fractures. Ultrasounds were completed for R hip and were negative fractures. CT (CAT Scan) has been ordered for the site. Statements are being collected from staff from the past 72 hours.</p> <p>On 06/27/24 at 1:01 PM, Resident #81 observed in a recliner chair in the room.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 07/01/24 at 8:54 AM, the surveyor reviewed the requested completed investigation and supporting documents related to the RER for Resident #81 that were provided by the Director of Nursing (DON). The DON confirmed the documents provided were all the documents that were part of the the completed investigation for the RER.</p> <p>A review of Resident #81's electronic medical record revealed:</p> <p>- The Quarterly Minimum Data Set, dated dated [DATE], revealed that the function status section indicated Resident #81 required Extensive assistance of one staff for toileting, transferring, bed mobility and transfer.</p> <p>-A Nursing Quarterly Evaluation, Effective 04/02/23, documented by a Licensed Practical Nurse (LPN); E. Mood/Behavior: C. Resistive During Care and D. Combative was checked; Skin condition #4, a. Skin is Intact; Activity: Degree of Physical Activity, Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.</p> <p>The Pain Evaluation revealed:</p> <p>A. Evaluation</p> <p>1. Manner of expressing pain:</p> <p>a. Verbal</p> <p>2. Ask resident: Have you had pain or hurting at any time in the last 5 days?</p> <p>0. No</p> <p>3. Ask resident: How much of the time have you experienced pain or hurting over the last 5 days?</p> <p>9. Unable to answer</p> <p>4. Ask resident: Over the past 5 days, has pain made it hard for you to sleep at night?</p> <p>0. No</p> <p>5. Ask resident: Over the past 5 days, have you limited your day-to-day activities because of pain?</p> <p>0. No</p> <p>11. Pain is Rated by:</p> <p>a. Numeric Rating Scale</p> <p>11a. Numeric Rating Scale (00-10) Ask resident: Please rate your worst pain over the last 5 days on a zero to ten scale, with</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>zero being no pain and ten as the worst pain you can imagine. (Show resident 00-10 pain scale). Enter two-digit response.</p> <p>Enter 99 if unable to answer.</p> <p>0</p> <p>-4/2/2023 08:58 Nursing Evaluation Note (Structured Progress Note) Late Entry, The resident is oriented to person. The resident is confused. Speech is clear. The resident speaks/understands Italian. The resident is resistive during care. The resident is combative. The resident takes antidepressant medication. The resident has no evidence of delirium. Fall Risk Score: 14.0</p> <p>Fall Risk Category: High Risk for Fall</p> <p>4/3/2023 11:56 Nursing</p> <p>Late Entry: Note Text: Resident was noted in AM (morning) with pain to right hip/leg. Resident was having difficulty walking. Nursing examined resident she was noted with edema to b/l LE (bilateral lower extremity), no redness or bruising was seen. Nursing informed Family, [Doctor], Director/NP [Nurse Practitioner]. Order placed for Xray of right hip, right femur, right Tib [tibula] and Fib [fibula] and right ankle. Results were negative for fracture. However, resident was still having pain. Resident family did not want sent to ER for CT [CAT] scan. Follow up Xray's ordered for the AM. PRN pain medication administered.</p> <p>A 4/6/2023 07:05, Nursing Note Text: 11 to 7 skilled nurses note: resident was in [their] chair resting at beginning of shift, able to assist resident to lay down with some degree of difficulty, resident favoring right hip/leg, c/o of pain, they slept through most of the night with occasional outbursts of talking and light moaning, we were able to perform morning care and able to get resident into bathroom to toilet, also resident allowed me to apply ace wraps to b/l [bilateral] lower legs. will continue to monitor</p> <p>4/6/2023 14:21 INTERACT SBAR (Situation, Background, Assessment, Summary- utilized with change in condition), Summary for Providers</p> <p>Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition</p> <p>Resident/Patient is in the facility for: Long Term Care</p> <p>Primary Diagnosis is: COVID-19</p> <p>UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY</p> <p>M15.9 POLYOSTEOARTHRITIS, UNSPECIFIED</p> <p>LOCALIZED SWELLING, MASS AND LUMP, LOWER LIMB, BILATERAL</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Wynwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Wynwood Drive Cinnaminson, NJ 08077	
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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>OTHER SPECIFIED PERSONAL RISK FACTORS, NOT ELSEWHERE CLASSIFIED</p> <p>Relevant medical history is: Dementia</p> <p>Resident/Patient had the following medications changes in the past week:</p> <p>Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:</p> <ul style="list-style-type: none"> <li>- Functional Status Evaluation: Needs more assistance with ADLs Decreased mobility</li> <li>- Skin Status Evaluation: Discoloration</li> <li>- Pain Status Evaluation: Does the resident/patient have pain? Yes</li> </ul> <p>Nursing observations, evaluation, and recommendations are: Resident was noted on 4/3/23 with pain to right hip, no redness or bruising seen at this time. On 4/6/23 Resident was noted with continued pain and 3 cm linear Bruise to right hip. Xrays completed on 4/3/23 and 4/4/23 no fracture noted, CT [CAT scan] recommended, Venous Doppler on 4/4/23 neg [negative] for DVT [deep vein thrombosis- blood clot] . CT set for 4/7/23. Family does not want resident to be sent out to ER (emergency room ) at this time. Continue to monitor and pain management in place.</p> <p>On 07/01/24 at 8:54 AM, the surveyor reviewed the requested Investigation provided by the Director of Nursing (DON) that was related to the RER for Resident #81. The DON confirmed the documents provided was the completed investigation and revealed the following:</p> <p>Description of Event: At 11:10 AM on 04/06/2023, notified that a 3 cm [centimeter] linear bruise was noted to right hip when APN [nurse practitioner] during exam. Resident was noted with new pain to the right hip on Monday 4/4/2023. Resident has advanced stage dementia and does not speak English. The Resident does ambulate without assistance at times in the room. Resident has a DX: osteoarthritis.</p> <p>Action:</p> <p>Full body assessment completed on residents with no other injuries noted; Investigation immediately initiated .</p> <p>Resident's Pertinent Medical Data: Alert and oriented to self with a Brief Interview for Mental Status 99 [severe cognitive impairment]. Resident is an extensive assist with all Activities of Daily Living. Diagnosis: Dementia, polyosteorthritis, hypokalemia, hypertension.</p> <p>Events Preceding Incident:</p> <p>Resident demonstrated new pain to the right hip area Monday 4/3/2023 .</p> <p>Statement Summary:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>At 11:10 AM on 04/06/23, notified that a 3 cm linear bruise was noted to right hip when APN was doing exam. Resident was noted with new pain to the right hip on Monday 04/04/2023. [This contradicted the documented information in the Events Preceding Incident section and the medical record]. Resident has advanced stage dementia and does not speak English. The resident does ambulate without assistance at times in the room. Resident was interviewed with daughter's assistance in translation. Resident stated that they fell but was unable to elaborate due to advanced dementia level. An investigation was initiated, and statements were gathered from all staff that were assigned to resident from Sunday 04/02/23 until 04/06/2023. No fall was reported .</p> <p>Conclusions:</p> <p>The IDC [Interdisciplinary Team] met to discuss and review the incident and has determined that the cause of the bruise was caused by an unwitnessed fall. A reasonable person would conclude that this was isolated incident and no abuse or neglect occurred. There was no intent to cause any harm. Investigational summary completed by: [DON].</p> <p>A review of the attached statements revealed the following 13 Witness Statements:</p> <p>-Incident Date: [Left Blank], Type of Incident [Left Blank], Please provide a written description of what you observed section: I [name toileted [Resident] on Sunday 04/02/2023 and did not complain of any pain.; Name, Title /Relation to Resident: Signed, Certified Nurse Aide and [Date: Blank].</p> <p>-Incident Date: 4/2/23, Type of Incident [Left Blank], Incident time- 11-7 shift; Please provide a written description of what you observed section: No falls or incidents occurred during my shift. Resident slept through the night with no [signs/symptoms] of pain or discomfort. Name, Title /Relation to Resident: Signed, LPN and Date: 04/2/23.</p> <p>-Incident Date: [Blank]; Type of Incident Skin Bruise, Please provide a written description of what you observed section: I did not see any bruise or Resident on my shift on 04/03/23, 3-11, Name, Title /Relation to Resident: Signed, [No Title and Date: Blank].</p> <p>-Incident Date: 4/6; Type of Incident Bruise; Please provide a written description of what you observed section: I cared for resident on 4/4 and I did not see any bruising on resident's hip; Name, Title /Relation to Resident: Signed, [No Title and Date: Blank].</p> <p>-Date: 04/04/23; Incident Date: [Left Blank]; Type of Incident Skin, Please provide a written description of what you observed section: I cared for resident on 04/04/23. No new skin change was reported. Resident in stable condition. Name, Title /Relation to Resident: Signed, [Licensed Practical Nurse (LPN) and Date: 04/04/23].</p> <p>-Incident Date: 4/6/23; Type of Incident Bruise; Please provide a written description of what you observed section: I cared for resident on 4/4 and I did not see any bruising on resident's hip; Name, Title /Relation to Resident: Signed, [No Title and Date: Blank].</p> <p>-Incident Date: 4/6/23; Type of Incident Bruise; Please provide a written description of what you observed section: I cared for resident on 4/5 and I did not see any bruising on resident's hip; Name, Title /Relation to Resident: Signed, [No Title and Date: Blank].</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Incident Date: 4/6/23; Type of Incident Bruise, Please provide a written description of what you observed section: No one brought to this writer's attention of any skin issues on the shift Name, Title /Relation to Resident: Signed, [No Title] and Date: 07/18/23 [Three months after incident].</p> <p>-Incident Date: 4/6; Type of Incident Bruise, Please provide a written description of what you observed section: I was not informed of any skin issue on the shift. Name, Title /Relation to Resident: Signed, [No Title and Date: Blank].</p> <p>-Incident Date: 4/6; Type of Incident Bruise Right Hip, Please provide a written description of what you observed section: Was not aware of said discoloration to hip or it was not reported during this shift staff. Name, Title /Relation to Resident: Signed, LPN Date: 04/06/23.</p> <p>-Incident Date: 4/6; Type of Incident Bruise Right Hip, Please provide a written description of what you observed section: I was not informed that resident had a bruise nor did I see a skin alteration to residents right hip. Name, Title /Relation to Resident: Signed, LPN, Date: [undated].</p> <p>-Incident Date: 4/6; Type of Incident Bruise Right Hip, Please provide a written description of what you observed section: I did not notice any bruise on the resident right hip during care. Name, Title /Relation to Resident: Signed, [No Title and Date: Blank].</p> <p>-Incident Date: 4/6/23; Type of Incident Bruise Right Hip, Please provide a written description of what you observed section: I care for the Resident today 04/06/23 I notice a small bruise to the right hip I notify the unit manager and nurse immediately informed. CNA Name, Date: Blank].</p> <p>-Incident Date: 4/6/23; Type of Incident Bruise Right Hip, Please provide a written description of what you observed section: I care for the Resident today 04/06/23 I notice a small bruise to the right hip I notify the unit manager and nurse immediately informed. CNA Name, Date: Blank.</p> <p>-Incident Date: 4/6/23; Type of Incident Bruise, Please provide a written description of what you observed section: I was informed this shift by NP that resident had a bruise on right hip. I am unaware of how/when this happened. Name, Title /Relation to Resident: Signed, [No Title and Date: 04/06/23].</p> <p>On 07/03/24 at 1:43 PM, the surveyor interviewed the DON in the presence of the survey team. The surveyor asked what would be completed when a new symptom would occur with a resident as Resident #81 had new complaint of pain to the right leg on 4/3/23 and was diagnosed with a hip fracture on 4/7/23. The DON stated typically the nurse would call the physician, regarding a change in condition would occur and notify family. The surveyor asked when the resident presented with new pain on 4/3 was that when the investigation began. The DON stated, typically I go back from when baseline changed and collect statements for 72 hours prior. The surveyor showed the DON the statements had missing dates and they did not go back 72 hours from 4/3/23. The DON stated the Unit Manager (UM) would obtain the statements and they were responsible for interviewing staff. The surveyor asked how abuse/neglect was ruled out and the DON did not offer a response. The surveyor asked the DON who was responsible for reviewing the investigation and she stated she reviewed it. The surveyor requested a timeline of events leading up to Resident #81's fracture.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 7/8/24 at 8:30 AM, the facility offered a one paged document which revealed on 04/02/23, a physician documented there was no pain changes. On 04/03/23, nursing noted new pain to right hip at 11:00 AM, Tylenol was administered and was ineffective. During the investigation, the [family] was able to obtain some information of the cause of the fracture. The resident's [family] stated that the resident stated they fell and could not get any additional information. There was no statement from the family, no documentation regarding the alleged fall and interviewing staff related to a fall, no additional statements were provided.</p> <p>On 07/08/24 at 3:09 PM, the Licensed Nursing Home Administrator (LNHA) provided a one page document which included a paragraph that the facility investigated the fracture appropriately . abuse ruled out . The LNHA provided no additional documented evidence related to the investigation to rule out abuse or neglect upon the reported new onset pain to the right hip/leg on 04/03/23, by Resident #81. No statements were provided going back 72 hours as indicated in the RER and as confirmed by the DON that they should have been completed.</p> <p>The Unexplained Injuries Policy, Date Reviewed/Reviewed 11/29/23, revealed all unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated.</p> <p>Section 3. An inci [TRUNCATED]</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48422</b></p> <p>Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure dependent residents were provided with routine and appropriate incontinence care and nail care in a timely manner. This deficient practice was identified for 8 of 8 residents reviewed for Activities of Daily Living Care (Residents #27, #30, #37, #41, #82, #94, #95, and #155) and was evidenced by the following:</p> <p>1) On 6/27/24 at 10:48 AM, surveyor #1 entered Resident #94's room and noted a strong odor of feces in the room. Resident #94 informed the surveyor that staff refused to assist with incontinence care. Upon request, Resident #94's roommate activated the call bell. The Licensed Practical Nurse/ Unit Manager (LPN/UM) reported to the room immediately, and confirmed that Resident #94 needed to be changed.</p> <p>2) On 6/27/24 at 11:06 AM, surveyor #1 observed Resident #82 in bed with fingernails long, jagged with a black coated substances underneath the fingernails. The resident informed the surveyor that they would like their nails to be trimmed and cleaned. A review of Resident #82's care plan indicated to check nail length, clean and/or trim on bath day, as necessary.</p> <p>3) On 06/28/24 at 6:30 AM, the surveyor entered room [ROOM NUMBER] which was a four bedded room and asked a random Certified Nurse Aide (CNA) to assist with incontinence care tour. The urine odor was permeated in the hallway. The first 3 residents were soaked with urine.(Resident #82, #37 and #41.)</p> <p>4) On 6/28/24 at 6:36 AM, during the Incontinence tour (IC), in the presence of CNA #3, surveyor #1 observed Resident #37 was saturated in urine. The surveyor interviewed CNA #1 who worked the 7:00 AM to 3:00 PM shift that day. CNA #1 stated that when the facility was short of staff, the residents would be soiled with urine and feces.</p> <p>5) On 6/28/24 at 6:45 AM, during IC, in the presence CNA #1, the surveyor observed Resident #41 in bed, saturated in urine.</p> <p>6) On 6/28/24 at 6:50 AM, during the IC, in the presence of CNA #1, the surveyor observed Resident #95 in bed, saturated in urine. The surveyor interviewed Resident #95. Resident #95 stated that they were provided with incontinence care during the night only.</p> <p>7) On 6/28/24 at 7:00 AM, Resident #30 was noted in bed, fully covered. The CNA informed the resident of the procedure and the resident agreed to be checked. The CNA pulled the blanket and we both observed that Resident #30 was covered with feces. The sheets were stained and soiled with urine and feces. Resident #30 had dry feces all over the abdomen and the night gown. The pulled sheet was yellow stained. The blue pads that were underneath the resident were stained and saturated with urine and feces. When the CNA attempted to assist Resident #30 with turning, we both observed that Resident #30 was wearing two incontinent briefs that were saturated and stained with urine and feces.</p> <p>On 6/28/24 at 7:25 AM, the surveyor asked CNA #1 to call the LPN/UM and the Director of Nursing (DON).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 6/28/24 at 7:35 AM, the LPN and the DON entered room [ROOM NUMBER] and both observed the condition of the resident. The LPN/UM stated that he assumed the resident had not been changed. They both observed that Resident #30 had 2 incontinent briefs on which were saturated with urine and feces. The DON further stated that the expectation was that all residents would be changed and maintained in a sanitary manner.</p> <p>On 6/28/24 at 7:50 AM, during an interview with the surveyor, CNA #1 stated that was not the first time she observed two incontinent briefs on residents during care. The CNA went on to state that the facility had provided in-services (education) to not apply double incontinence briefs on residents. However, she stated that if the facility was short handed during the 11:00 PM-7:00 AM shift, some residents would have double briefs and would not be changed in a timely manner.</p> <p>On 07/08/24 at 2:12 PM, surveyor #1 conducted a telephone interview with CNA #2 who cared for Resident #30 on 6/28/24 during the 11:00 PM to 7:00 AM shift. During the interview CNA #2 stated, when I went to check them, I did not turn on the light, and fully open the incontinence brief . The CNA also stated that the facility was short handed, only 2 CNAs were assigned to care for 45 Residents. She checked the resident at 2:30 AM and did not realized that Resident #30 was wearing double briefs. The CNA added, I was running late and I did not check them again. CNA #2 informed the surveyor that the 3:00 PM- 11:00 PM shift applied the double incontinent briefs.</p> <p>On 07/08/24 at 2:15 PM, the surveyor again called CNA #3 who worked the 3:00 PM-11:00 PM shift on 6/27/24. She did not return the call. The DON informed the surveyor that CNA #3 confirmed that she provided care to Resident #30 around 10:30 PM and applied the double incontinent briefs.</p> <p>8) On 7/3/24 at 12:13 PM, surveyor #2 interviewed Resident #27. Resident #27 who is awake and alert informed the surveyor that they were left soiled for hours sometime in September 2023. Resident #27 could not recall the exact date, but remember that incontinence care was provided around 10:00 PM, and was not changed again until 10:00 AM on the next day. Resident #27 further stated that they were not offered incontinence care on the 11:00 PM - 7:00 AM shift. Resident #27 informed surveyor #3 that they reported the above concerns to the DON and the Licensed Nursing Home Administrator (LNHA) at that time, and had not seen that staff member since; I think she was terminated. Resident #27 stated residents who were dependent on staff for care still had to wait over an hour before they could be changed. Resident #27 went on to state, They still have to wait an hour or longer for incontinence care. Resident #27 stated they just don't have enough help.</p> <p>9) On 7/8/24 at 10:11 AM, surveyor #1 interviewed Resident #155's Representative (RR) (a discharged resident). The RR stated that Resident #155 was left in a chair for an extended period of time without being changed. The RR informed the surveyor that Resident #155 was currently hospitalized and could not participate with the interview.</p> <p>A review of the facility's policy titled, Activities of Daily Living (ADL's), Support revised March 2018, revealed the following: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living; Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>NJAC 8:39-27.1 (a)2(g)(h)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27193</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) implement interventions to prevent the development of a stage IV facility acquired pressure injury, b.) ensure individualized comprehensive care plan interventions were implemented to prevent facility acquired pressure injury wound from worsening, and c.) ensure daily observation during wound care was documented according to professional standards of Nursing practice to follow continuity of care, and d) alert physician of any change in the wound condition. This deficient practice occurred for 1 of 2 closed records reviewed for wounds (Resident #150). Resident #150 was identified as having a skin tear to the left lower leg at the facility on 10/09/23, which measured 2 centimeters (cm) x 2 cm x 0.2 cm which progressed to necrotic exposed bone protruding through the right lower extremity which was identified during routine wound rounds by a consultant on 12/19/23, and which resulted in a right above the knee amputation three days later.</p> <p>The evidence was as follows:</p> <p>On 6/28/24 at 12:30 PM, the surveyor reviewed the closed electronic medical record (EMR) for Resident #150. Review of the closed record revealed that Resident #150 was admitted to the facility with diagnoses which included but were not limited to; Benign prostatic hyperplasia, dementia in other diseases classified elsewhere and failure to thrive and dementia.</p> <p>According to the Annual Minimum Data Set (MDS), an assessment tool dated 8/7/23, Resident #150 was identified as having moderate cognitive impairment. Resident #150 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #150 was totally dependent on staff for all Activities of Daily Living (ADLs).</p> <p>Further review of the MDS in section M, indicated that the resident had no history of an unhealed unstageable pressure injury and was at risk of developing a pressure injury. Further review of section M indicated under Skin and Ulcer/Injury Treatments that the following were applied: pressure reducing device for bed, nutrition and application of ointments.</p> <p>Review of the Order Summary Report((OSR) revealed a Physician Order (PO) dated 07/23/23, for a low air mattress. Check placement and functioning every shift.</p> <p>Review of the OSR revealed a PO dated 11/02/23, for blue pillow wrap to be donned (put on) on the left lower extremity to decrease risk of skin breakdown. Skin check every shift.</p> <p>Review of the Order Summary Report (OSR) dated November 2023, revealed a physician's order (PO) dated 11/22/23, to cleanse the wound with acetic acid, do not scrub or use excessive force, apply calcium alginate cut to size daily, covered with a bordered foam dressing daily.</p> <p>Another order dated 11/29/23, was to cleanse the right hip with acetic acid, do not scrub or use excessive force. Apply calcium alginate cut to to size, covered with a bordered foam dressing daily.</p> <p>Review of the Weekly Skin Review dated 11/02/23, and signed by a Licensed Practical Nurse (LPN) revealed a skin tear which measured 1.1 centimeter (cm) x 0.9 cm x 0.2 cm.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 11/09/23 (7 days later), indicated No new skin alterations. No measurement was entered on the skin assessment.</p> <p>On 11/16/23, Right anterior lower leg 5.0 cm x 2.5 x 0.2 cm.</p> <p>On 11/23/23, Right anterior lower leg 6.5 cm x 3.5 cm x 0.2 cm. Signed 11/25/23.</p> <p>On 11/30/23, right lower leg 7.0 cm x 5.5 cm x 0.4 cm. Right hip 3.0 cm x 2.5 cm x 0.4 cm. Signed 12/04/23.</p> <p>On 12/05/23, Resident #150 was transferred to the hospital. During wound rounds, the Nurse Practitioner identified that the wound was infected with a large amount of purulent drainage. The resident was admitted to the hospital and treated for osteomyelitis (Infection of the bone).</p> <p>Review of the electronic Treatment Administration Record (eTAR) from November 2023 through December 2023, revealed the eTAR was initialed to reflect that skin checks were being completed on the Thursday evening shift. Bath and shower were initialed as being done on the Monday and Thursday evening shift. Both were signed by the Licensed Practical Nurse (LPN). There was no documentation in the progress notes regarding the wound condition. The facility indicated that the wound was treated daily by staff, however, there was no documentation regarding that the wound had signs of being infected.</p> <p>Review of the eTAR for November and December 2023, reflected the Blue pillow was being applied as ordered to prevent skin breakdown.</p> <p>On 07/01/24, the surveyor interviewed the Licensed Practical Nurse Unit Manager regarding the process for wound care. He informed the surveyor that the nurses would initial the eTAR only. No narrative documentation was available regarding the wound condition. Wound condition was documented weekly during wound rounds.</p> <p>On 12/05/23, Resident #150 was transferred to the hospital after the consultant wound care practitioner informed the facility that the wound was infected.</p> <p>The nurses were to provide wound care daily and document/report any change in the wound condition. The physician and the wound care team was not informed that the wound was infected.</p> <p>At the hospital on 12/06/23, the following documentation was entered in the electronic medical record (EMR) regarding the wound:</p> <p>Right Hip Pressure Injury: Active present on admission.</p> <p>wound description Full Thickness Wound.</p> <p>wound length (cm) centimeter: 2.5</p> <p>wound width (2.5 cm)</p> <p>wound depth (0.2 cm) Pressure injury stage Stage 3( present on admission)</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Wynwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Wynwood Drive Cinnaminson, NJ 08077	
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Contributing Factors: Lower extremities contractures, urinary incontinence, decreased mobility. Bed/Mobility: 2 person assist to turn.</p> <p>Bowel/ Bladder: Condom Catheter.</p> <p>Interventions/ recommendations:</p> <p>Cleanse wound with Normal Saline, cover with Meplex Border small sacral foam dressing, change dressing every 3 days.</p> <p>Continue to turn and reposition every 2 hours using foam wedge to maintain side-lying position.</p> <p>The resident was discharged to the facility on [DATE].</p> <p>The History and Physical entered in the EMR by the treating physician on 12/08/23, indicated the following: Resident #150 was readmitted to (Long Term Care) LTC after an acute hospitalization after presenting with right lower leg wound. Imaging revealed right tibia osteomyelitis. Resident #150 was started on an antibiotic which they will complete on 12/15 and 12/16/23. Resident #150 was transferred back to the LTC facility in stable condition.</p> <p>Review of the skin incident report dated 12/5/23, revealed the following: Interdisciplinary Team met to discuss recent wound deterioration, Resident currently on Low air loss mattress, wedge in place, turning and positioning for pressure relief, daily wound rounds. Upon surveyor inquiry, the facility was unable to provide the rationale for staff not documenting the wound condition while wound care was being done daily. The facility did not identify any change in condition.</p> <p>Resident #150 was then readmitted to the facility on [DATE] in stable condition. The facility indicated that wound care was being completed daily. However, on 12/19/23, again during wound rounds, Resident #150 was found to have protruding necrotic bone upon assessment of the wound by the consultant wound practitioner. On the same day, 12/19/23 Resident #150 was transferred to the Emergency Department, and diagnosed with fracture of the Tibia and Fibula. The surveyor reviewed the hospital record from the hospitalization of 12/19/23, and the following were noted:</p> <p>-Comments: Right lower extremity: Contracture with flexion at the hip and knee. Significant wound on the anterior shin with exposed bone .</p> <p>-A 12/19/23 Hospital Radiology X-Ray report revealed Acute Fractures of the right proximal tibia and fibular diaphysis [right thigh long bones], additional clinical notes revealed, now presents 12/19 from the skilled nursing facility because of bone extruding through wound, as well as hematuria ([Urinary Catheter] inserted 12/17 for urinary retention) per hospital follow up with the facility the wound dressing was changed daily and the facility had no documentation regarding bone exposure and found during weekly wound observation, orthopedic plans for a Right aka [above the knee amputation] on 12/22.</p> <p>On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the Director of Nursing (DON) regarding an investigation about the wound development and related to exposed bone. The DON stated she was not at the facility and that there was nothing else to provide.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of a policy titled Unexplained Injuries last revised 11/29/23 revealed:</p> <p>All unexplained injuries, including bruises, abrasions and inquiries of unknown origin will be investigated.</p> <p>Policy Explanation and Compliance Guidelines: Observations of any unexplained injuries shall be reported immediately to the resident's nurse. Care and treatment shall be provided to the resident as needed. This includes physician notification, and implementation of physician orders or facility protocols. Relevant information shall be documented in the resident's medical record, including but not limited to: physical assessment findings, including objective description of the injury.</p> <p>The facility shall modify the resident's plan of care as needed to prevent recurrence or to stabilize, reduce, or remove underlying risks factors contributing to the injury. The facility failed to follow their own policy. Resident #150 was found to have an infected wound with purulent drainage by the nurse practitioner during wound rounds on 12/05/23. On 12/19/23 again the consultant nurse practitioner identified during wound round that Resident #150 had protruding necrotic bone to the right anterior lower leg.</p> <p>On 07/08/24 at 11:33 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) about Resident #150's wound. The LNHA stated, I talked to the family at some point, and reviewed the case later. The LNHA had no additional information to provide.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48422</p> <p>Complaint #167264</p> <p>Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure sufficient and competent staff were available to a) provide timely and appropriate incontinence care for residents who were dependent on staff for Activities of Daily Living (ADL's) care (Residents #94, #30, #37, #41, #95, and #27), b) provide nail care for a resident who was dependent of staff for ADL's (Resident #82) and c) ensure staff were competent to accurately document an allegation of sexual abuse and alert the supervisor. The deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Refer to 600 K and 677F</p> <p>a) On 6/27/24 at 10:48 AM, surveyor #1 was doing the initial tour of the facility and was informed by Resident #94 that staff refused to change them. The surveyor noted a foul odor in the room. The call bell was activated by the roommate and the Unit Manager Licensed Practical Nurse (UMLPN) reported to the room immediately and confirmed Resident #94 was soiled with excrement.</p> <p>On 6/28/24 between the hours of 6:30 AM and 6:50 AM, surveyor #1 observed a care tour in the presents of the Certified Nursing Aide (CNA).</p> <p>At 6:30 AM, surveyor #1 and the CNA observed Resident #30 covered with feces and urine that had saturated the double incontinent briefs, the bed protector, and the sheets of the bed. The Director of Nursing (DON) and the UMLPN were called to the room, and both confirmed the status of the resident's condition and that the resident was double briefed. The DON stated that her expectations would be that all residents would be changed and maintained in a sanitary manner. The CNA revealed that was not the first occurrence of a resident being double briefed. The CNA further stated that if the unit was short of staff the resident would be soiled in the morning.</p> <p>On 06/28/24 at 7:25 AM, the surveyor asked the CNA to call the Unit Manager and the DON, both observed the condition that the resident was left in. At that time, an interview with the UM revealed that he assumed that</p> <p>the resident had been changed. Both also observed that Resident was wearing double incontinent briefs. During an interview with the DON, she stated that her expectations would be that all residents would be changed and maintained in a sanitary manner. The DON further stated that she would investigate. At that time, an interview with the CNA revealed that that was not the first time resident's had been found with double briefs on and they received in-service on not to have double brief on the residents. The CNA further stated that if the unit was short of staff the resident would be soiled in the morning.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 7/8/24 at 2:12 PM, surveyor #1 interviewed the CNA who cared for Resident #30 on 6/28/24 on the 11:00 PM to 7:00 AM shift. The CNA stated, when I went to check him/her, I did not open the incontinent brief fully. The CNA also stated there was only 2 CNA's working that night and Resident #30 was last checked at 2:30 AM. The CNA stated, I was running late and did not check them again.</p> <p>At 6:36 AM, surveyor #1 and the CNA observed Resident #37 was saturated in urine. The CNA stated that when the facility was short of staff the resident would be soiled with urine and feces.</p> <p>At 6:45 AM, surveyor #1 and the CNA observed Resident #41 in bed and was saturated in urine.</p> <p>At 6:50 AM, surveyor #1 and the CNA observed Resident #95 in bed and was saturated with urine. During the interview with Resident #95, the resident stated they were changed last night and had not been changed that morning.</p> <p>On 7/3/24 at 12:13 PM, surveyor #2 interviewed Resident #27 who stated that sometime in September they were left soiled from 10:00 PM and was not changed until the next day around 10:00 PM. The Resident could not remember an exact date, but he/she did not have care provided by the 11:00 PM to 7:00 AM shift CNA. The Resident stated that the DON and Administrator were notified of the situation and did not see the CNA after that day. Resident #27 stated, I think she was terminated. Resident #27 further stated still finds that they are waiting an hour or longer for incontinent care. The Resident also stated that the CNA's are doing there best, but they just don't have enough help.</p> <p>b) On 6/27/24 at 11:06 AM, surveyor #1 observed Resident #82 in bed with fingernails overgrown, jagged and with black substances underneath about 1 inch. The resident stated that they would like their fingernails to be cleaned.</p> <p>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes.</p> <p>The following ratio(s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>Staffing had been calculated for the following time frames and revealed the following:</p> <p>1. For the 2 weeks of staffing from 06/25/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:</p> <p>-06/25/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-06/29/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.</p> <p>-06/30/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs.</p> <p>-07/01/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-07/02/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs.</p> <p>-07/08/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs.</p> <p>2. For the 2 weeks of staffing from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:</p> <p>-07/30/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs.</p> <p>-08/05/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.</p> <p>-08/06/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs.</p> <p>-08/07/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.</p> <p>-08/12/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs.</p> <p>3. For the 4 weeks of staffing from 11/19/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 13 of 28 day shifts as follows:</p> <p>-11/19/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>-11/25/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-11/26/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-11/27/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-11/29/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.</p> <p>-11/30/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs.</p> <p>-12/02/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs.</p> <p>-12/03/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.</p> <p>-12/07/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.</p> <p>-12/09/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs.</p> <p>-12/10/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-12/12/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.</p> <p>-12/16/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.</p> <p>4. For the 2 weeks of staffing prior to survey from 06/09/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:</p> <p>-06/15/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.</p> <p>-06/16/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.</p> <p>-06/21/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.</p> <p>-06/22/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.</p> <p>c) On 6/28/24 at 7:30 AM, in the presence of the surveyor, Resident #94 told the Liscensed Practical Nurse (LPN) that they were upset that [Resident #84] came into their room and touched their feet and penis. The surveyor then asked the LPN if she heard what Resident #94 had said. The LPN stated, I heard it, management was already made aware. Resident #84 resided in the adjacent room connected through a shared bathroom from Resident #94.</p> <p>On 07/01/24 at 12:29 PM, the surveyor interviewed Resident #71 who was Resident #94's roommate. Resident #71 stated, my roommate got violated by [Resident #84] last night and that the facility informed the resident that Resident #84 was allowed to wander because the resident was confused. Resident #71 further stated, we were half asleep and we are not sure of what [Resident #84] is capable of doing. Resident #71 further stated that Resident #84 had been wandering into their rooms for months and that was reported to the nurses, the Certified Nurse Aides (CNA), and the Unit Manager (UM).</p> <p>On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the UM, [Resident #84] violated me. [Resident #84] always comes into our room. [Resident #84] touched my feet and this time [Resident #84] stuck their hands in my pants and touched my penis. [Resident #84] had never touched my penis before. I told the staff a million times and nothing had been done.</p> <p>On 07/01/24 at 12:35 PM, the surveyor, along with a second surveyor, then interviewed the LPN, whom Resident #94 reported the alleged sexual abuse on 6/28/24 at 7:30 AM, in the presence of the UM. The LPN confirmed that Resident #94 reported the allegation of sexual abuse on 6/28/24 at 7:30 AM. The LPN stated in the presence of the UM that Resident #94 informed her that Resident #84 touched Resident #94 in a [redacted derogatory word for homosexual] way. The LPN confirmed to the UM, I did not write it, that was Resident #94's perception.</p> <p>NJAC 8:39-4.1</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31654</p> <p>Based on observation, interview and document review it was determined that the administrator failed to ensure the facility operated in a manner to ensure residents were consistently provided with care to maintain their highest practicable physical, mental, and psychosocial well-being by failing to ensure: a) a process was in place to ensure a resident (Resident #84) with known wandering behaviors was effectively supervised to prevent the resident from sustaining an injury and preventing the resident from sexually abusing another resident (Resident # 94, b) adverse and significant events were thoroughly investigated (Resident #81 and #150, Resident #94), c) wound care was consistently documented to ensure that staff were able to identify and report any change in a wound condition to the physician. Resident #150 developed a wound at the facility which progressed to the bone protruding which then required an amputation. d) an elopement was reported to the Department of Health as required, e) staffing was adequate to meet dependent residents activity of daily living care including incontinence care for 8 of 8 residents reviewed (Residents #27, #30, #37, #41, #82, #94, # 95, and #155), and f) an effective Quality Assurance and Performance Improvement Program was compressive and self-identified concerns, including residents who required close supervision when smoking, held their own lighter and lit other resident's cigarettes, had burn holes in their smoking aprons and who discarded cigarette ashes in the bushes. This deficient practice had the potential to effect all residents who resided in the facility was evidenced by the following:</p> <p>Refer to: 600 K, 609D, 610H, 686H, 689L, 725F, 865F</p> <p>a) On 06/27/24 during the facility entrance conference conducted with the Licensed Nursing Home Administrator (LNHA), Director of Nursing and the Corporate Nurse the facility Quality Assurance and Performance Improvement Policies were requested and provided by the LNHA.</p> <p>An Immediate Jeopardy (IJ) situation began on 06/04/24, and was identified on 07/01/24. Resident #84 had a documented history of wandering into other resident rooms that began on 02/22/24.</p> <p>On 06/04/24, Resident #84 wandered into Resident #152's room. Resident #152 then shoved Resident #84 which caused Resident #84 to fall, and sustained a skin tear to the left elbow.</p> <p>On 06/28/24 at 7:30 AM, Resident #94 in the presence of the surveyor, told the Licensed Practical Nurse (LPN) that they were upset that Resident #84 wandered into their room, placed their hands under the bed sheets, and touched Resident # 94's feet and penis.</p> <p>This failure to adequately supervise a cognitively impaired resident with a known history of wandering into other resident rooms and touching other residents in an inappropriate sexual manner placed all residents at an increase risk for the likelihood of serious injury or serious physical or psychosocial harm. This resulted in an Immediate Jeopardy (IJ) situation.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b)The facility failed to ensure a thorough and complete investigation was completed to determine the causal factor of injuries of unknown origin to ensure that resident abuse or neglect had not occurred for: a) a resident (Resident #150) who was found on 12/05/23, with an infected wound that required hospitalization on [DATE], and was diagnosed with osteomyelitis, and again observed during routine wound rounds on 12/19/23, with exposed bone and required transfer to the hospital on the same day, and was diagnosed with acute fractures of the right proximal tibia and fibular diaphyses (two long thigh bones) on 12/19/23, b) an allegation of sexual abuse by Resident #94 that was reported to the Licensed Practical Nurse on 6/28/24 at 7:30 AM, the facility did not investigate the allegation until 7/1/24, c) and for a resident who had a history of being combative with care, reported new onset of pain to the right hip/leg on 04/03/23, and was diagnosed with a comminuted mildly displaced fracture at the greater trochanter of the right hip on 04/07/23. This deficient practice occurred for 3 of 3 residents reviewed for abuse (Resident # 81 and #150, Resident #94).</p> <p>On 07/08/24 at 3:12 PM, the LNHA stated regarding the documentation for Resident #150's wound care, that we need to keep up on documentation, the nurses that did treatments did not document. The LNHA had no additional information to provide regarding the skin tear progressing to a bone protruding and Resident #150 requiring an amputation.</p> <p>c) The facility failed to: a.) implement interventions to prevent the development of a stage IV facility acquired pressure injury, b.) ensure individualized comprehensive care plan interventions were implemented to prevent facility acquired pressure injury wound from worsening, and c.) ensure daily observation during wound care was documented according to professional standards of Nursing practice to follow continuity of care, and d) alert physician of any change in the wound condition. This deficient practice occurred for 1 of 2 closed records reviewed for wounds (Resident #150). Resident #150 was identified as having a skin tear to the left lower leg at the facility on 10/09/23 which measured 2 centimeters (cm) x 2 cm x 0.2 cm which progressed to necrotic exposed bone protruding through the right lower extremity which was identified during routine wound rounds by a consultant on 12/19/23, and which resulted in a right above the knee amputation three days later.</p> <p>The evidence was as follows:</p> <p>On 6/28/24 at 12:30 PM, the surveyor reviewed the closed medical record for Resident #150.</p> <p>On 6/28/24, the surveyor reviewed the closed electronic medical record (EMR) for Resident #150. Review of the closed record revealed that Resident #150 was admitted to the facility with diagnoses which included but were not limited to; Benign prostatic hyperplasia, dementia in other diseases classified elsewhere and failure to thrive and dementia.</p> <p>According to the Annual Minimum Data Set (MDS), an assessment tool dated 8/7/23, Resident #150 was identified as having moderate cognitive impairment. Resident #150 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS). Resident #150 was totally dependent on staff for all Activities of Daily Living (ADLs).</p> <p>Further review of the MDS in section M, indicated that the resident had no history of an unhealed unstageable pressure injury and was at risk of developing a pressure injury. Further review of section M indicated under Skin and Ulcer/Injury Treatments that the following applied: pressure reducing device for bed, nutrition and application of ointments.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Order Summary Report (OSR) dated 11/23, revealed a physician's order (PO) dated 11/22/23, to cleanse the wound with acetic acid, do not scrub or use excessive force, apply calcium alginate cut to size daily, covered with a bordered foam dressing daily.</p> <p>Another order dated 11/29/23 was to cleanse the right hip with acetic acid, do not scrub or use excessive force. Apply calcium alginate cut to to size, covered with a bordered foam dressing daily.</p> <p>Review of the OSR revealed a PO dated 11/02/23, for blue pillow wrap to be donned (put on) on the left lower extremity to decrease risk of skin breakdown. Skin check every shift.</p> <p>Review of the OSR revealed a PO dated 07/03/23, for a low air mattress. Check placement and functioning every shift.</p> <p>Review of the Weekly Skin Review dated 11/02/23, and signed by a Licensed Practical Nurse (LPN) revealed a skin tear which measured 1.1 centimeter (cm) x 0.9 cm x 0.2 cm.</p> <p>On 11/09/23 (7 days later), indicated No new skin alterations. No measurement was entered on the skin assessment.</p> <p>The Resident's wound progressed to the following and there was no investigation to determine why the wound progressed to having a weekly wound consultant identify protruding bone on the right lower extremity which was not identified by staff at the facility.</p> <p>A 12/19/23 Hospital Radiology X-Ray report revealed Acute Fractures of the right proximal tibia and fibular diaphysis [right thigh long bones], additional clinical notes revealed, now presents 12/19 from the skilled nursing facility because of bone extruding through wound, as well as hematuria ([Urinary Catheter] inserted 12/17 for urinary retention) per hospital follow up with the facility the wound dressing was changed daily and the facility had no documentation regarding bone exposure and found during weekly wound observation, orthopedic plans for a Right aka [above the knee amputation] on 12/22.</p> <p>On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the Director of Nursing regarding an investigation about the wound development and related to exposed bone. The DON stated she was not at the facility and that there was nothing else to provide.</p> <p>d.) On 07/02/24 at 1:15 PM, the surveyor asked the DON if a resident jumped out of a window. The DON confirmed that Resident #87 eloped and went through the window and it was witnessed by a nurse and aide. The DON stated she completed an incident report and the surveyor requested a copy. The surveyor asked the DON if the elopement was reported to the DOH. The DON stated, no, only Administrator.</p> <p>On 07/02/24 at 1:29 PM, the surveyor conducted an interview with the Unsampled Resident (UR) roommate of Resident #87 regarding the incident. The UR stated Resident #87 climbed out of the window and that the Certified Nurse Aide was in the room and then went out of the window after Resident #87 exited.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/02/24 at 2:30 the DON provided statements regarding the incident which revealed Heard resident hitting window. Window fell open. Resident jumped out. Alerted the aide and immediately followed out. Brought patient back. Dated 05/12/24 (untitled staff). Another statement, with Incident date: 05/12/24, Incident Time: 9:15 PM, revealed this nurse was coming down the hall when aide informed me that Resident #87 had jumped out the window and nurse with resident outside . The Incident Report dated 05/12/24 revealed that on 05/12/24 at approximately 9:15 PM, the assigned nurse for Resident #87 observed the resident banging on the window, then saw the window dislodge and saw the resident climb out of the window and the nurse followed outside of the window.</p> <p>On 07/08/24 at 12:16 PM, the surveyor interviewed the Maintenance Director (MD) regarding the resident who exited out through the window. The MD stated there were brackets that prevented the window from opening all the way. The MD showed the surveyor a cut metal bracket with one screw through the bracket and the MD confirmed that was a facility derived device. The MD stated Resident #87 pulled so hard that the screws were pulled out.</p> <p>On 07/08/24 at 3:10 PM, the LNHA responded to the surveyor concerns regarding Resident #87 jumping out the window and the LNHA stated we did not think it met the reportable requirement, it was an anomaly.</p> <p>e.) a) On 6/27/24 at 10:48 AM, surveyor #1 was doing the initial tour of the facility and was informed by Resident #94 that staff refused to change them. The surveyor noted a foul odor in the room. The call bell was activated by the roommate and the Unit Manager Licensed Practical Nurse (UMLPN) reported to the room immediately and confirmed Resident #94 was soiled with excrement.</p> <p>On 6/28/24 between the hours of 6:30 AM and 6:50 AM, surveyor #1 observed a care tour in the presence of the Certified Nursing Aide (CNA).</p> <p>At 6:30 AM, surveyor #1 and the CNA observed Resident #30 covered with feces and urine that had saturated the double incontinent briefs, the bed protector, and the sheets of the bed. The Director of Nursing (DON) and the UMLPN were called to the room, and both confirmed the status of the resident's condition and that the resident was double briefed. The DON stated that her expectations would be that all residents would be changed and maintained in a sanitary manner. At that time, an interview with the UM revealed that he assumed that Resident #30 did not receive incontinence care during the 11:00 PM-7:00 AM shift. The CNA revealed that was not the first occurrence of a resident being double briefed and they received in-service on not to have double brief on the residents. The CNA further stated that if the unit was short of staff the resident would be soiled in the morning.</p> <p>On 7/8/24 at 2:12 PM, surveyor #1 interviewed the CNA who cared for Resident #30 on 6/28/24 on the 11:00 PM to 7:00 AM shift. The CNA stated, when I went to check him/her, I did not open the incontinent brief fully. The CNA also stated there was only 2 CNA's working that night and Resident #30 was last checked at 2:30 AM. The CNA stated, I was running late and did not check them again.</p> <p>At 6:36 AM, surveyor #1 and the CNA observed Resident #37 was saturated in urine. The CNA stated that when the facility was short of staff the resident would be soiled with urine and feces.</p> <p>At 6:45 AM, surveyor #1 and the CNA observed Resident #41 in bed and was saturated in urine.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Quality Assurance and Performance Improvement Policy (QAPI), Date reviewed/Revised 02/20/23 revealed: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. An adverse Event is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof. 2c. Develop and implement appropriate plans of actions to correct quality deficiencies. d. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regiment reviews, and act on available data to make improvements. 3. The QAPI plan will address the following elements: c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i. Tracking and measuring performance, ii. Establishing goals and thresholds for performance improvements, iii. Identifying and prioritizing quality deficiencies, iv. Systematically analyzing underlying causes of systemic quality deficiencies, v. Developing and implementing corrective action or performance improvement activities, vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. D. A prioritizations of program activities that focus on resident safety, health outcomes, autonomy, choice and quality of care, as well as, high- risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves. The facility must also consider the incidents, prevalence, and severity of problems or potential problems identified.</p> <p>The LNHA also provided signature sheets for a two QAPI meetings, one on 01/18/24 and 05/16/24 and he was signed in as the NHA [ Nursing Home Administrator] and no other representation as a Nursing Home Administrator was documented as being in attendance.</p> <p>On 07/08/24 at 8:20 AM, the surveyor requested the LNHA to provide all current active QAPI for review with survey team.</p> <p>On 07/08/24 at 10:27 AM, the surveyor interviewed the LNHA in the presence of two surveyors. The surveyor asked the LNHA, who stated he has been the LNHA since 12/2023. The surveyor inquired what QAPIs had he transitioned from the former LNHA, and what he identified as concerns to be reviewed at QAPI. The LNHA stated pharmacy presents at QAPI and the surveyor asked exactly what the facility is monitoring that is measurable and quantifiable for QAPI, and what were the QAPIs that were identified and initiated since he assumed the LNHA role. The LNHA stated falls, food quality, and stated food quality was transitioned from the former LNHA. The LNHA stated food service was a high priority issue. The LNHA stated palatability of the food was a concern and also tray tickets not matching what was served. The surveyor asked about the concerns identified during the survey, which included the known wandering resident with the subsequent allegation of sexual abuse, the resident who wore double incontinence briefs and the concerns regarding incontinence care, the residents who held their own lighters and safe smoking concerns and the resident The LNHA stated he was never aware of residents having double incontinence briefs. The LNHA confirmed that the issue of smoking was never brought to QAPI as he was unaware. The surveyor asked if any adverse, significant or reportable events had been brought to QAPI. The LNHA stated they don't review significant or reportable events at QAPI. The LNHA added that significant events were not reviewed, but I can certainly add them. The surveyor asked if wounds were reviewed at QAPI and the LNHA reviewed his QAPI binder and stated wounds were not part of QAPI. The surveyor asked the LNHA if he was an LNHA and he stated yes and informed the surveyor of his training.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/08/24 at 11:33 AM, the surveyor asked specifically about a review of the fracture for Resident #150 and the LNHA stated, I talked to the family at some point and then I reviewed the case later.</p> <p>On 07/08/24 at 1:10 PM, the survey team met with the LNHA and Director of Nursing (DON). The surveyor reiterated the concerns regarding the incomplete investigations and Resident #84 the known to be a wanderer and the surveyor asked about a root cause analysis completed and was this brought to QAPI. The LNHA stated no.</p> <p>On 07/08/24 at 3:12 PM, the LNHA stated regarding the documentation for Resident #150's wound care, that we need to keep up on documentation, the nurses that did treatments did not document.</p> <p>The surveyor reviewed the QAPI program provided by the LNHA for review and the identified concerns were not addressed in QAPI.</p> <p>NJAC 8:39-27.1(a)</p>

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31654</p> <p>Based on interview and document review it was determined that the facility failed to have an effective systems and procedures for feedback in place to self identify areas for Quality Assurance and Performance Improvement (QAPI) for: a) a resident documented as a known wanderer that wandered into other resident rooms since 02/22/24, had a history of being injured by another resident after wandering into another resident room and then sexually abused another resident (Resident #94) on 07/01/24, b) residents who smoked, held their own lighting materials, lit other residents, cigarettes, burned their own clothing, staff disposing of cigarette waste inappropriately(Resident #29, #39, #72, #87 and #32), c) ensuring residents were provided with appropriate incontinence and activity of daily living care for 8 of 8 residents reviewed (Residents #27, #30, #37, #41, #82, #94, #95, and #155), and d) adverse events and reportable events for residents with fractures requiring hospitalization (Resident #81 and #150) . This deficient practice was identified during an on-site survey conducted from 06/25/24-07/15/24 and had the potential to affect all residents and was evidenced by the following:</p> <p>Refer to 600K, 610H, 689L, 686H, and 677F</p> <p>On 06/27/24 during the facility entrance conference conducted with the Liscensed Nursing Home Administrator (LNHA), Director of Nursing and the Corporate Nurse the facility Quality Assurance and Performance Improvement Policies were requested and provided by the LNHA.</p> <p>The Quality Assurance and Performance Improvement Policy (QAPI), Date reviewed/Revised 02/20/23 revealed: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. An adverse Event is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof. 2c. Develop and implement appropriate plans of actions to correct quality deficiencies. d. Regularly review and analyze date, including data collected under the QAPI program and data resulting from drug regiment reviews, and act on available data to make improvements. 3. The QAPI plan will address the following elements: c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i. Tracking and measuring performance, ii. Establishing goals and thresholds for performance improvements, iii. Identifying and prioritizing quality deficiencies, iv. Systematically analyzing underlying causes of systemic quality deficiencies, v. Developing and implementing corrective action or performance improvement activities, vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. D. A prioritization of program activities that focus on resident safety, health outcomes, autonomy, choice and quality of care, as well as, high- risk, high-volume, or problem-prone areas as identified in the facility assessment that reflects the specific units, programs, departments and unique population the facility serves. The facility must also consider the incidents, prevalence, and severity of problems or potential problems identified.</p> <p>The LNHA also provided signature sheets for a two QAPI meetings, one on 01/18/24 and 05/16/24 and he was signed in as the NHA [ Nursing Home Administrator] and no other representation as a Nursing Home Administrator was documented as being in attendance.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>a) On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the UM, [Resident #84] violated me. [Resident #84] always comes into our room. [Resident #84] touched my feet and this time [Resident #84] stuck their hands in my pants and touched my penis. [Resident #84] had never touched my penis before. I told the staff a million times and nothing had been done.</p> <p>A review of the electronic medical record for Resident #84 revealed (EMR):</p> <p>- 02/22/2024 timed 06:53:41 AM, Resident # 84 watching Television at HS [Hour of Sleep] and rearranging wall poster, nursing monitoring throughout the shift, resident emerged approximately at 5:00 AM, and began exit seeking. The resident stated they were looking for the way out, wandering to other resident's rooms. The resident was escorted away by staff, nursing continuing to monitor will endorse to day shift.</p> <p>- A nursing note created 3/3/2024 timed 19:32:19 [7:32 PM] indicated the following: Resident continues to wander around the facility into other residents rooms and was noted on more then one occasion leaving their cell phone unattended.</p> <p>6/3/2024 timed 13:56 PM [1:56 PM], the nurse's notes revealed the following entry: alerted by staff, another Resident #152 shoved [Resident #84] out of their room. Attempted to de-escalate behavior with 1:1 support. 9-1-1 was called for assistance. Full body assessment completed with no injuries noted. MD [medical doctor] and family notified of incident. Resident #152 was sent to crisis for evaluation. The above note was entered in the EMR on 6/4/2024 at 12:27:23 PM.</p> <p>On 07/01/24 at 12:29 PM, the surveyor interviewed Resident #71 who was Resident #94's roommate. Resident #71 stated, my roommate got violated by [Resident #84] last night and that the facility informed the resident that Resident #84 was allowed to wander because the resident was confused. Resident #71 further stated, we were half asleep and we are not sure of what [Resident #84] is capable of doing. Resident #71 further stated that Resident #84 had been wandering into their rooms for months and that was reported to the nurses, the Certified Nurse Aides (CNA), and the Unit Manager (UM).</p> <p>On 07/01/24 at 12:31 PM, the surveyor, along with a second surveyor, interviewed Resident #94. Resident #94 stated in the presence of the UM, [Resident #84] violated me. [Resident #84] always comes into our room. [Resident #84] touched my feet and this time [Resident #84] stuck their hands in my pants and touched my penis. [Resident #84] had never touched my penis before. I told the staff a million times and nothing had been done.</p> <p>b) On 7/1/2024, a surveyor observed Resident #39 light resident #29's cigarette, leave the smoking area and entered the facility while in possession of the lighting material. Resident #29, a resident with contractures of the right elbow, wrist and hand who was assessed as requiring close supervision while smoking was not adequately supervised, and staff did not assist the resident while smoking. The right hand was visibly shaking, then the resident rested their lit cigarette on their visibly charred and ripped smoking apron, then picked up the cigarette again and continued to smoke. The surveyor then observed a Certified Nurse Aide (CNA) take Resident #29's smoking apron and disposed the ashes over the patio and into the bushes.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/02/24 at 11:16 AM, the concerns related to residents who smoked, held their own lighters and liter other cigarettes was discussed with the LNHA. The LNHA stated that residents should not be lighting other resident cigarettes.</p> <p>c) On 06/27/24 and 06/28/24 during multiple observations surveyors observed:</p> <p>-6/27/24 at 10:48 AM, surveyor #1 entered Resident #94's room and noted a strong odor of feces in the room. Resident #94 informed the surveyor that staff refused to assist with incontinence care. Upon request, Resident #94's roommate activated the call bell. The Licensed Practical Nurse/ Unit Manager ( LPN/UM) reported to the room immediately, and confirmed that Resident #94 needed to be changed.</p> <p>- 6/27/24 at 11:06 AM, surveyor #1 observed Resident #82 in bed with fingernails long, jagged with a black coated substances underneath the fingernails. The resident informed the surveyor that they would like their nails to be trimmed and cleaned. A review of Resident #82's care plan indicated to check nail length, clean and/or trim on bath day, as necessary.</p> <p>-06/28/24 at 6:30 AM, the surveyor entered room [ROOM NUMBER] which was a four bedded room and asked a random Certified Nursing Assistant (CNA) to assist with incontinence care tour. The urine odor was permeated in the hallway. The first 3 residents were soaked with urine.(Resident #82, #37 and #41.)</p> <p>- 6/28/24 at 6:36 AM, during the Incontinence tour (IC), in the presence of CNA #3, surveyor #1 observed Resident #37 was saturated in urine. The surveyor interviewed CNA #1 who worked the 7:00 AM to 3:00 PM shift that day. CNA #1 stated that when the facility was short of staff, the residents would be soiled with urine and feces.</p> <p>On 07/03/24 at 1:43 PM, the surveyor interviewed the DON in the presence of the survey team regarding an investigation for Resident #82's fracture. The surveyor asked what would be completed when a new symptom would occur with a resident as Resident #81 had new complaint of pain to the right leg on 4/3/23 and was diagnosed with a hip fracture on 4/7/23. The DON stated typically the nurse would call the physician, re: don, and new symptom would occur and notify family. The surveyor asked when the resident presented with new pain on 4/3 was that when the investigation began. The DON stated, typically I go back from when baseline changed and collect statements for 72 hours prior. The surveyor showed the DON the statements had missing dates and they did not go back 72 hours from 4/3/23 and that the Unit Manager would obtain the statements and they were responsible for interviewing staff. The surveyor asked how abuse/neglect was ruled out and the DON did not offer a response. The surveyor asked the DON who was responsible for reviewing the investigation and she stated she reviewed it.</p> <p>d)1. On 07/02/24 at 11:30 AM, the surveyor reviewed all progress notes which revealed a 10/18/23 nurses Skin Check note indicating that Resident #150 had a skin tear at the facility on the right anterior lower leg measuring 2 centimeters (cm) x 2 cm x 0.3 cm. The right hip was noted with an abscess measuring 2 cm x 2 cm x 0.2 cm. Interventions implemented for the wound were low air loss mattress, pillows between legs and bilateral heel booties. The wound had worsened and the facility did not document anything regarding the wound condition in the EMR. There was no documentation in the EMR that indicated the physician was made aware of the condition of the wound.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  Wynwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Wynwood Drive Cinnaminson, NJ 08077	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Order Summary Report dated 11/2023, reflected an order dated 11/22/23 to cleanse the wound of the right anterior lower leg topically every day shift for wound, cleanse with acetic acid, do not scrub or use excessive force. pat dry, apply honey gel to wound, apply calcium alginate cut to size of wound base, cover with a bordered foam dressing.</p> <p>The right hip wound had an order, dated 11/29/23, to cleanse with acetic acid, do not scrub or use excessive force, pat dry, apply honey gel to wound, apply calcium alginate cut to size of wound base cover with a bordered foam dressing. The staff initialed the Treatment Administration Record (TAR) from 12/1/23 to 12/5/23 indicating that the wound care was completed as ordered.</p> <p>On 12/05/23, at 21:15 [9:15 PM] Discharge Summary, for a Date of Discharge from the facility on 12/05/23 revealed Resident #150 . wound to right anterior lower leg is reclassified as Stage 4 pressure injury . . purulent drainage and edema to the periwound. Unable to debride [remove dead tissue] due to the patient being severely contractive and combative. Recommend patient be sent to hospital for possible osteomyelitis. According to nursing notes, patient was admitted for wound infection.</p> <p>The Hospital record for Resident #150 for the Emergency Department to Hospital Admission which began on 12/05/23 was obtained by the Department of Health (DOH) and revealed:</p> <p>Emergency Department (ED) Provider Note dated 12/05/23 at 11:00 revealed:</p> <p>-Initial Complaint:</p> <p>Patient presents with wound infection coming from rehab with a wound to RLE (right lower extremity with concern for infection + [positive] malodorous and oozing . Past medical history of dementia currently living in a nursing home with contractures patient with know wounds. Nonverbal and non-interactive. History and physical completed at the hospital upon admission on 12/5/23, revealed the following: History of failure to thrive, Parkinson disease, dementia who presents from a Long Term Care Facility (name redacted) due to right lower leg wound with symptoms and signs of infection with needs for debridement. Resident #150 was diagnosed with osteomyelitis.</p> <p>The surveyor reviewed the hospital record from the hospitalization of 12/19/23 and the following were noted:</p> <p>-Comments: Right lower extremity: Contracture with flexion at the hip and knee. Significant wound on the anterior shin with exposed bone .</p> <p>-A 12/19/23 Hospital Radiology X-Ray report revealed Acute Fractures of the right proximal tibia and fibular diaphysis [right thigh long bones], additional clinical notes revealed, now presents 12/19 from the skilled nursing facility because of bone extruding through wound, as well as hematuria (Foley inserted 12/17 for urinary retention) per hospital follow up with the facility the wound dressing was changed daily and the facility had no documentation regarding bone exposure and found during weekly wound observation, orthopedic plans for a Right aka [above the knee amputation] on 12/22.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/03/23 at 2:00 PM, in the presence of the survey team, the surveyor inquired to the DON, with the LNHA present, regarding an investigation about the wound development and then related to exposed bone. The DON stated she was not at the facility and had nothing to provide other than what was already provided. When inquired to the LNHA stated he was aware of Resident #150 having exposed bone and stated resident was severely contracted and provided no addition information.</p> <p>2. A Reportable Event Record/Report (RER) was received by the Department of Health (DOH) on 04/06/2023 regarding Resident #81 which revealed: Date of Event: 04/06/2023, Time of Event: 11:10 AM. 1. Narrative: At 11:10 AM on 04/06/23, notified that a 3 cm (centimeter) linear bruise noted to R (right) hip on Monday 04/04/2023. Resident has advanced stage dementia and does not speak English. Resident does ambulate without assistance at times in room. Resident has a Dx. (diagnosis) osteopenia and osteoarthritis. 3. Resident was assessed for further injuries and no further injuries were noted. X-rays were completed for R hip, R femur, and R knee and were negative for fractures. Ultrasounds were completed for R hip and were negative fractures. CT (CAT Scan) has been ordered for the site. Statements are being collected from staff from the past 72 hours. On 7/8/24 at 8:30 AM, the facility offered a one paged document titled which revealed on 04/02/23 a physician documented there was no pain changes.</p> <p>On 04/03/23 nursing noted new pain to right hip at 11:00 AM, Tylenol was administered and was ineffective. During the investigation, the [family] was able to obtain some information of the cause of the fracture. The resident's [family] stated that the resident stated they fell and could not get any additional information. There was no statement from the family, no documentation regarding the alleged fall and interviewing staff related to a fall, no additional statements were provided.</p> <p>On 07/08/24 at 8:20 AM, the surveyor requested the LNHA to provide all current active QAPI for review with survey team.</p> <p>On 07/08/24 at 10:27 AM, the surveyor interviewed the LNHA in the presence of two surveyors. The surveyor asked the LNHA, who stated he has been the LNHA since 12/2023. The surveyor inquired what QAPIs had he transitioned from the former LNHA, and what he identified as concerns to be reviewed at QAPI. The LNHA stated pharmacy presents at QAPI and the surveyor asked exactly what the facility is monitoring that is measurable and quantifiable for QAPI, and what were the QAPIS that were identified and initiated since he assumed the LNHA role. The LNHA stated falls, food quality, and stated food quality was transitioned from the former LNHA. The LNHA stated food service was a high priority issue. The LNHA stated palatability of the food was a concern and also tray tickets not matching what was served. The surveyor asked about the concerns identified during the survey, which included the known wandering resident with the subsequent allegation of sexual abuse, the resident who wore double incontinence briefs and the concerns regarding incontinence care, the residents who held their own lighters and safe smoking concerns and the resident The LNHA stated he was never aware of residents having double incontinence briefs. The LNHA confirmed that the issue of smoking was never brought to QAPI as he was unaware. The surveyor asked if any adverse, significant or reportable events had been brought to QAPI. The LNHA stated they don't review significant or reportable events at QAPI. The LNHA added that significant events were not reviewed, but I can certainly add them. The surveyor asked if wounds were reviewed at QAPI and the LNHA reviewed his QAPI binder and stated wounds were not part of QAPI. The surveyor asked the LNHA if he was an LNHA and he stated yes and informed the surveyor of his training.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 07/08/24 at 11:33 AM, the surveyor asked specifically about a review of the fracture for Resident #150 and the LNHA stated, I talked to the family at some point and then I reviewed the case later.</p> <p>On 07/08/24 at 1:10 PM, the survey team met with the LNHA and Director of Nursing (DON). The surveyor reiterated the concerns regarding the incomplete investigations and Resident #84 the known to be a wanderer and the surveyor asked about a root cause analysis completed and was this brought to QAPI. The LNHA stated no.</p> <p>On 07/08/24 at 3:12 PM, the LNHA stated regarding the documentation for Resident #150's wound care, that we need to keep up on documentation, the nurses that did treatments did not document.</p> <p>The surveyor reviewed the QAPI program provided by the LNHA for review and the identified concerns were not addressed in QAPI.</p> <p>NJAC 8:39-33.2(a)(b)(c)1,3</p>