| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315047 | A. Building<br>B. Wing | 07/15/2024 |

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| Wynwood Rehabilitation and Healthcare Center | 1700 Wynwood Drive<br>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) |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The removal plan indicated the facility took the following steps to prevent serious harm from occurring or recurring:<br><br>The immediacy of the IJ was removed on 07/01/24.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>The evidence was as follows:<br><br>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 .<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>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).<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>On 07/01/24, the surveyor reviewed the electronic medical record (EMR) for Resident #94 which revealed:<br><br>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.<br><br>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).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | The Care Plan (CP), initiated and revised on 05/22/24, indicated that the resident had fear from symptoms of anxiety, Educate about source of fear. Explore past coping skills and encourage resident to utilize coping strategies.<br><br>2. On 07/01/24, at 9:30 AM, the surveyor reviewed the EMR Resident #84 which revealed:<br><br>The Admission Summary revealed Resident #84 was admitted to the facility on [DATE], with diagnoses which included but were not limited to; Wernicke's Encephalopathy (a sudden and severe brain disorder that causes brain damage causing confusion, memory loss typically caused by alcohol addiction), unspecified psychosis not due to a substance or known physiologic condition, alcohol dependence, restlessness and agitation.<br><br>The Quarterly Minimum Data Set (MDS), dated [DATE], reflected the resident had a BIMS score of 4 out of 15, which indicated the resident was severely cognitively impaired. The MDS also revealed that Resident #84 required assistance from staff for activities of daily living (ADLs).<br><br>A review of a 41-page Care Plan which included current and canceled focus areas revealed the following focus areas:<br><br>- A focus area initiated on 02/17/24, for risk for elopement with a Goal that Resident #84 will not leave the building without escort through review date, with a Target Date of 09/05/24. The CP interventions included to apply wander guard (a bracelet that a resident wears, sensors that monitor doors and a technology platform that sends safety alerts in real time) and check for proper function and placement, date initiated 02/27/24.<br><br>- A focus area initiated on 06/16/24, for a behavioral problem of wandering in other residents' rooms with a Goal, initiated 06/16/24, to have a lesser episode of this behavior til [until] next review, with a Target Date of 09/05/24. The CP interventions initiated 06/16/24 included to: Anticipated resident needs, arrange for psychiatric consult as ordered, Help me understand why the behavior is socially inappropriate, Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from the situation and take to an alternate location as needed, Intervene PRN [as needed] to ensure safety of resident and others (i.e., talk with resident in a calm manner, divert attention, take to another location PRN), Monitor behavior to assist in determining the cause. This Focus area was initiated four months after it was initially documented on 02/22/24, when the resident wandered into another resident's room.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | - A focus area initiated on 04/19/24, and revised 06/03/24, for I am at risk for misappropriation, neglect, abuse and/or exploitation related to cognitive impairment. Another resident allegedly shoved me. The Goal, initiated on 04/19/24, with a Target date of 09/05/24, I will not experience any form of abuse, neglect, misappropriation and/or exploitation through review date. The CP interventions included, 1:1 visits with me from all departments as needed, Initiated 04/19/24. Assess me for s/s [signs and symptoms] of abuse and or neglect (ex. Bruises, weight loss, behavior, psychological status) and report to appropriate resources, Initiated 04/19/24. I was in the bathroom and I accidentally entered into my neighbor's room through the opposite bathroom door and I touched their foot, skin checks for three days, pain evaluation, social worker visits for three days, psychology and psychiatry consult, Initiated 06/28/24. Investigate all allegations of abuse and neglect promptly, Initiated 04/19/24. My bathroom door has a sign to remind me which door to go back out through, Initiated 06/28/24. Place bigger sign on door with resident's name, Initiated 06/03/24. Please redirect me to an activity or distraction if you see me wandering, Initiated 06/03/24.<br><br>Further review of Resident #84's Medical Record revealed the following progress note entries:<br><br>- 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.<br><br>- 02/23/2024 at 22:49:00 [10:49 PM], Resident was wandering both units all shift. Resident can be hard to redirect. Nursing attempted to offer activities, coloring books, newspaper - resident refused. Resident was noted with urinating in inappropriate places again the resident was not easily redirected. Wander guard is in place and functioning.<br><br>- 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. Cell phone was placed in safe at reception for safe keeping.<br><br>- 03/27/2024 at 14:58 [2:58 PM] Daily Skilled Documentation revealed the following: Received Resident walking around the unit. Resident wanders around attempting to walk into other residents' rooms, able to be redirected. Resident denies pain or discomfort.<br><br>- A nursing note dated 05/22/2024 at 06:54:17 revealed the following documentation: Resident up at 1:00 AM, going in and out of their room. At this time, the resident went into room [ROOM NUMBER], and before we could get to the room, the resident was urinating in two laundry baskets. The resident was immediately redirected back to their room, they continued to go in and out of other resident rooms and up and down the halls for the rest of the night. Unable to redirect. No further behaviors noted.<br><br>- On 05/23/2024 at 07:02:43 the following documentation was entered: Resident was up most of the night walking the halls and talking to themselves. The resident was going into other resident's rooms and going behind the nurses' station. The resident needed redirection and 1:1 most of the night which was ineffective for this resident. The resident was monitored and redirected all shift.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | - 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.<br><br>- 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.<br><br>- 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.<br><br>- 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 .<br><br>- 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.<br><br>- 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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>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.<br><br>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 a inappropriate sexual manner or protect Resident #84 from other residents.<br><br>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 Resdient #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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>NJAC 8:39 - 4.1 (a)(5) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>31654<br><br>Based on interview and document review, it was determined that the facility failed to ensure they reported to the Department of Health (DOH) as required, a resident who was confused, wandered, identified as being exit seeking, and who broke a latch on a window and exited to the outside. This deficient practice occurred for 1 of 9 residents reviewed for accidents (Resident #87) and was evidenced by the following:<br><br>On 07/02/24 at 12:00 PM, the surveyor reviewed the electronic medical record for a resident identified as a smoker, Resident #87. A Nurses Progress Note, created by a Liscensed Practical Nurse (LPN) on 05/12/2024 at 21:48 [8:21 PM] revealed Informed by an aide that the resident had jumped out of window and primary nurse and aide was with the resident. The nurse remained with the resident while staff brought the wheelchair out and brought the resident back in. Director of Nursing (DON) informed of incident. Wanderguard to ankle still intact and functioning.<br><br>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.<br><br>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 Nuse Aide was in the room and then went out of the window after Resident #87 exited.<br><br>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.<br><br>A review of Resident #87's electronic medical record revealed that the Admission Summary indicated, but was not limited to, the following diagnoses; alcohol dependence with withdrawal delirium, difficulty walking and schizoeffective disorder, unspecified.<br><br>An informed consent for use of a wanderguard (a device applied to a resident that alarms when a resident exits through a door), dated May 10, 2024 revealed what assessed medical symptoms would be addressed by use of this wanderguard: Confusion, Wandering and Exit Seeking; What are the benefits of using a wanderguard for this resident and what is the likelihood of these benefits: Safety of the resident to prevent elopement/ wandering outside of the facility.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 stated Resident #87 pulled so hard that the screws were pulled out.<br><br>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 and stated we did not think it met the reportable requirement, it was an anomaly.<br><br>NJSA 8:39-5.1(a) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>Complaint #s NJ 163250, NJ 170219<br><br>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).<br><br>The deficient practice was as follows:<br><br>Refer to F600K, F686G<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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 Administraation Record (TAR) from 12/1/23 to 12/5/23 indicating that the wound care was completed as ordered.<br><br>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.<br><br>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:<br><br>Emergency Department (ED) Provider Note dated 12/05/23 at 11:00 PM revealed:<br><br>-Initial Complaint:<br><br>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.<br><br>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.<br><br>The hospital documentation revealed on 12/06/23, regarding the wound prior to discharge back to the facility on [DATE].<br><br>Right Hip Pressure Injury: Active present on admission.<br><br>wound description Full Thickness Wound.<br><br>wound length( cm) centimeter: 2.5<br><br>wound width (2.5 cm)<br><br>wound depth (0.2 cm) Presure injury stage Stage 3( present on admission)<br><br>Contributing Factors:Lower extremities contractures, urinary incontinence, decreased mobility. Bed/Mobility: 2 person assist to turn.<br><br>Bowel/ Bladder: Condom Catheter.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Interventions/ recommendations:<br><br>Cleanse wound with Normal Saline,cover with Meplex Border small sacral foam dressing, change dressing every 3 days.<br><br>Continue to turn and reposition every 2 hours using foam wedge to maintain side-lying position.<br><br>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.<br><br>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.<br><br>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. Subsequenty, 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].<br><br>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.<br><br>- 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.<br><br>There was no documented evidence that the above findings were communicated to the physician or the wound care team prior to 12/05/23.<br><br>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.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | The facility provided an incident report dated 12/19/23, with the following:<br><br>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.<br><br>Immediate action taken: Assessed by wound care team<br><br>Obtain order to send to emergency room<br><br>Notify responsible party of changes.<br><br>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.<br><br>The surveyor reviewed the hospital record from the hospitalization of 12/19/23, and the following were noted:<br><br>-Comments: Right lower extremity: Contracture with flexion at the hip and knee. Significant wound on the anterior shin with exposed bone .<br><br>-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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>The surveyor continued with the Medication Administration and observed Resident #84 in the hallway near their room.<br><br>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.<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | On 07/01/24 at 1:27 PM, the surveyor interviewed the SW again regarding the allegation of sexul 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.<br><br>On 7/01/24 at 1:30 PM, the surveyor reviewed the facility's policy on abuse, neglect and misappropriation.<br><br>Under Reporting/ Response:<br><br>The facility will have written procedure that include:<br><br>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:<br><br>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<br><br>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.<br><br>Assuring that reporters are free from retaliation or reprisal;<br><br>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.<br><br>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.<br><br>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.<br><br>On 06/27/24 at 1:01 PM, Resident #81 observed in a recliner chair in the room.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>A review of Resident #81's electronic medical record revealed:<br><br>- 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.<br><br>-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.<br><br>The Pain Evaluation revealed:<br><br>A. Evaluation<br><br>1. Manner of expressing pain:<br><br>a. Verbal<br><br>2. Ask resident: Have you had pain or hurting at any time in the last 5 days?<br><br>0. No<br><br>3. Ask resident: How much of the time have you experienced pain or hurting over the last 5 days?<br><br>9. Unable to answer<br><br>4. Ask resident: Over the past 5 days, has pain made it hard for you to sleep at night?<br><br>0. No<br><br>5. Ask resident: Over the past 5 days, have you limited your day-to-day activities because of pain?<br><br>0. No<br><br>11. Pain is Rated by:<br><br>a. Numeric Rating Scale<br><br>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<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | zero being no pain and ten as the worst pain you can imagine. (Show resident 00-10 pain scale). Enter two-digit response.<br><br>Enter 99 if unable to answer.<br><br>0<br><br>-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<br><br>Fall Risk Category: High Risk for Fall<br><br>4/3/2023 11:56 Nursing<br><br>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.<br><br>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<br><br>4/6/2023 14:21 INTERACT SBAR (Situation, Background, Assessment, Summary- utilized with change in condition), Summary for Providers<br><br>Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition<br><br>Resident/Patient is in the facility for: Long Term Care<br><br>Primary Diagnosis is: COVID-19<br><br>UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY<br><br>M15.9 POLYOSTEOARTHRITIS, UNSPECIFIED<br><br>LOCALIZED SWELLING, MASS AND LUMP, LOWER LIMB, BILATERAL<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | OTHER SPECIFIED PERSONAL RISK FACTORS, NOT ELSEWHERE CLASSIFIED<br><br>Relevant medical history is: Dementia<br><br>Resident/Patient had the following medications changes in the past week:<br><br>Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:<br><br>- Functional Status Evaluation: Needs more assistance with ADLs Decreased mobility<br><br>- Skin Status Evaluation: Discoloration<br><br>- Pain Status Evaluation: Does the resident/patient have pain? Yes<br><br>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 Brusie 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 4/723. Family does not want resident to be sent out to ER (emergency room ) at this time. Continue to monitor and pain management in place.<br><br>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:<br><br>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.<br><br>Action:<br><br>Full body assessment completed on residents with no other injuries noted; Investigation immediately initiated .<br><br>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, polyosteorathritis, hypokalemia, hypertension.<br><br>Events Preceding Incident:<br><br>Resident demonstrated new pain to the right hip area Monday 4/3/2023 .<br><br>Statement Summary:<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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 .<br><br>Conclusions:<br><br>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].<br><br>A review of the attached statements revealed the following 13 Witness Statements:<br><br>-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].<br><br>-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.<br><br>-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].<br><br>-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].<br><br>-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].<br><br>-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].<br><br>-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].<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | -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].<br><br>-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].<br><br>-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.<br><br>-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].<br><br>-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].<br><br>-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].<br><br>-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.<br><br>-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].<br><br>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.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>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.<br><br>The Unexplained Injuries Policiy, Date Reviewed/Reviewed 11/29/23, revealed all unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated.<br><br>Section 3. An inci [TRUNCATED] |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>38680<br><br>Based on interview, and record review, it was determined that the facility failed to complete a Significant Change in Status Assessment using the Resident Assessment Instrument (RAI) process on a resident who elected hospice benefits. This deficient practice was identified for 1 of 2 residents reviewed for hospice (Resident #44). This deficient practice was evidenced by:<br><br>According to the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual, A significant change in status assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later that the date of the hospice election statement, but not earlier than). The SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.<br><br>Resident #44 was admitted to the facility with diagnoses that included cancer and hypertension. On 07/02/24 at 9:33 AM, the surveyor observed Resident #44 in the room.<br><br>On 07/02/2024 at 8:49 AM the surveyor reviewed the resident's current physician's order sheet (POS). The POS revealed an order for hospice consult and treat dated 3/26/24. The POS reflected that hospice services began on 3/26/24.<br><br>Review of the Significant Change in Status Minimum Data Set (SCSA-MDS), an assessment used to facilitate the management of care, revealed the Assessment Reference Date (ARD) was 4/6/24. The MDS was signed as completed by the MDS Coordinator on 4/29/24.<br><br>On 07/03/24 at 9:00 AM, the surveyor interviewed the MDS Coordinator who has been employed since April 2024.The Coordinator confirmed that the resident was admitted to hospice on 3/26/24 and confirmed that a SCSA-MDS was scheduled for 4/6/24 and completed on 4/29/24. She stated the SCSA-MDS should have been completed within 14 days of the election of hospice services. She confirmed that the SCSA-MDS for Resident #44 was completed 20 days late.<br><br>NJAC 8:39-11.2(i) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48422<br><br>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:<br><br>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.<br><br>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.<br><br>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.)<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>On 6/28/24 at 7:25 AM, the surveyor asked CNA #1 to call the LPN/UM and the Director of Nursing (DON).<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>NJAC 8:39-27.1 (a)2(g)(h) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315047 | A. Building<br>B. Wing | 07/15/2024 |

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| Wynwood Rehabilitation and Healthcare Center | 1700 Wynwood Drive<br>Cinnaminson, NJ 08077 |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193<br><br>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.<br><br>The evidence was as follows:<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 11/09/23 (7 days later), indicated No new skin alterations. No measurement was entered on the skin assessment.<br><br>On 11/16/23, Right anterior lower leg 5.0 cm x 2.5 x 0.2 cm.<br><br>On 11/23/23, Right anterior lower leg 6.5 cm x 3.5 cm x 0.2 cm. Signed 11/25/23.<br><br>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.<br><br>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).<br><br>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.<br><br>Review of the eTAR for November and December 2023, reflected the Blue pillow was being applied as ordered to prevent skin breakdown.<br><br>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.<br><br>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.<br><br>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.<br><br>At the hospital on 12/06/23, the following documentation was entered in the electronic medical record (EMR) regarding the wound:<br><br>Right Hip Pressure Injury: Active present on admission.<br><br>wound description Full Thickness Wound.<br><br>wound length (cm) centimeter: 2.5<br><br>wound width (2.5 cm)<br><br>wound depth (0.2 cm) Pressure injury stage Stage 3( present on admission)<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Contributing Factors: Lower extremities contractures, urinary incontinence, decreased mobility. Bed/Mobility: 2 person assist to turn.<br><br>Bowel/ Bladder: Condom Catheter.<br><br>Interventions/ recommendations:<br><br>Cleanse wound with Normal Saline, cover with Meplex Border small sacral foam dressing, change dressing every 3 days.<br><br>Continue to turn and reposition every 2 hours using foam wedge to maintain side-lying position.<br><br>The resident was discharged to the facility on [DATE].<br><br>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.<br><br>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.<br><br>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:<br><br>-Comments: Right lower extremity: Contracture with flexion at the hip and knee. Significant wound on the anterior shin with exposed bone .<br><br>-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.<br><br>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.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A review of a policy titled Unexplained Injuries last revised 11/29/23 revealed:<br><br>All unexplained injuries, including bruises, abrasions and inquiries of unknown origin will be investigated.<br><br>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.<br><br>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.<br><br>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.<br><br>NJAC 8:39-27.1(a) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>27193<br><br>Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for the application of resting hand splint to the right hand for one resident. The deficient practice was identified for 1 of 1 resident (Resident #71) reviewed for positioning and mobility, and was evidenced by the following:<br><br>On 6/27/24 at 10:30 AM, the surveyor toured the unit. During the tour of the facility, Resident #71 reported some concerns with lack of physical therapy and assistance with Range of Motion (ROM) to prevent further contractures to the right hand. The resident used the left hand to pick up the right hand under the cover and show the contracted hand to the surveyor. The right hand was contracted, the fingers were curled into the palm of the right hand.<br><br>On 6/28/24 at 8:30 AM, the surveyor observed the resident in bed, the resident informed the surveyor that they did not get any assistance with ROM and the staff had not applied the resting splint for months.<br><br>On 6/28/24 at 11:15 AM, the surveyor reviewed Resident #71's Electronic Medical Record (EMR) The admission Face Sheet reflected that Resident #71 was admitted to the facility with diagnoses which included but were not limited to; hemiplegia and hemiparesis, following cerebral infarction affecting right dominant side, peripheral vascular disease and chronic pain.<br><br>According to the Quarterly Minimum Data Set (MDS), an assessment tool, dated 4/1/24, Resident #71 was identified as having intact cognition. Resident #71 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. Additionally, the resident was dependent on staff with most activities of daily living, and having impaired use of the upper and lower extremities on one side of the body.<br><br>On 07/01/24 at 12:17 PM, the surveyor observed Resident #71 sitting in the bed, At that time, the surveyor did not observe the resting hand splint applied to the resident. The resident informed the surveyor again, it had not been on.<br><br>On 07/02/24 at 10:10 AM, the surveyor entered the room and verified that the soft hand splint was not applied. The surveyor reviewed the Treatment Administration Record (TAR) and verified that staff had initialed the TAR indicating that the soft hand splint had been applied even on the days the surveyor observed that Resident #71 did not have the soft hand splint on.<br><br>On 07/02/24 at 9:30 AM, the surveyor reviewed the Order Summary Report dated July 2, 2024, which included a physician's order dated 1/24/24 for Don resting hand splint to right upper extremity in the morning and remove at night before bed. With regular skin checks and cleaning, every morning and at bedtime.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The surveyor also reviewed Resident #71's June 2024 and July 2024,Treatment Administration Record (TAR). The physician order was noted on the TAR which required the nurse's signatures for the 8:00 a.m. application and the 21:00 (9:00 p.m.) removal of the soft hand splint each day. From 06/28/24 to 07/08/24, the TAR revealed the nurses initialed the TAR indicative that the soft hand splint was applied.<br><br>On 07/08/24 at 9:30 AM, the surveyor observed the resident in bed, the resident showed the right hand to the surveyor and indicated again that they had not had the splint on for months. The surveyor left the room and accompanied the Regional Nurse to the room. In the presence of the Regional Nurse, the resident stated that they had not received any assistance with Range of Motion for months, and the Staff had not applied the soft resting splint for months. The Resident informed the Regional Nurse in the presence of the surveyor that the splint could be possibly in the top dresser. The Regional Nurse opened the dresser and noted that the splint was in the dresser.<br><br>The surveyor reviewed the Progress notes from June to July 2024, there was no documentation regarding refusal of the splint.<br><br>The surveyor further reviewed the Nursing Progress Notes from May 2024 to July 2024. The Nursing Progress Notes did not reveal that Resident #71 refused to wear the soft resting hand splint.<br><br>The surveyor reviewed Resident #71's ongoing Care Plan (CP). The CP revealed an area of Focus related to Activities of Daily Living( ADL) self care deficit related to hemiplegia right side, initiated 09/29/23 last revised 11/16/23. The CP further reflected an intervention dated 01/24/24 for Resting hand splint to the right hand during the day. Please put on in the morning and remove at night before bed.<br><br>Review of the facility's policy titled, Range of Motion last revised 11/29/23 included the following:<br><br>Residents who enter the facility without limited range of motion, will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable.<br><br>Appropriate Care Planning<br><br>Based on the comprehensive assessment, the facility will provide interventions, exercises and /or therapy to maintain and improve range of motion.<br><br>The facility will provide treatment and care in accordance with professional standards of practice This includes but not limited to:<br><br>Appropriate services ( specialized rehabilitation, restorative, maintenance)<br><br>Appropriate equipment (braces, splint)<br><br>Assistance as needed (active assisted, passive, supervision)<br><br>The policy was not being followed<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | .<br><br>NJAC 8:39-27.1 (a) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449<br><br>Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to have a system in place to ensure a consistent and safe smoking process for 17 residents who were identified as smokers by failing to ensure a) provision of adequate and consistent supervision for residents who were assessed and identified as smokers, b) residents who required close monitoring when smoking, did not keep their own lighting materials and then used it to light other residents' cigarettes (Resident #30 and #72), c) residents who required close monitoring and supervision while smoking, were assisted and supervised to prevent embers from the cigarettes from causing burn holes and ensuring the lit cigarette was not rested on the smoking apron causing cinder type marks (Resident #29), and d.) extinguishing cigarettes into appropriate receptacles and that cigarette ashes were appropriately disposed of. This deficient practice was identified for 5 of 17 residents (Resident #29, #39, #72, #87 and #32) reviewed for safe smoking and posed the likelihood of serious injury, serious impairment or harm to all residents who resided at the facility.<br><br>On 7/1/2024, the surveyor observed Resident #39 light resident #29's cigarette, leave the smoking area and enter 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.<br><br>On 7/2/2024, Resident #72 was observed by surveyors lighting their own cigarette, and other residents' cigarettes (including Resident #29) with a lighter. The surveyors observed six cigarette butts located directly on the bushes below the smoking balcony. During an interview, Resident #29 stated their clothing had cigarette burned holes. The surveyors again observed Resident #29 resting their lit cigarette on their smoking apron which remained charred throughout and ripped in several areas.<br><br>The IJ situation began on 7/1/2024 and was identified on 7/2/2024. The Licensed Nursing Home Administrator (LNHA) was notified on 07/02/2024 at 2:46 PM.<br><br>The facility provided an Immediate Jeopardy Removal Plan (RP) that was accepted on 7/3/24 at 10:00 AM, indicating the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice which included:<br><br>1. On 7/2/24 at 1:00 PM, the Licensed Nursing Home Administrator met with Resident #72 and was asked if they had lighting material and was given permission to audit the resident's room for lighting material and none were found. On 7/2/24 at 12:20 PM, Resident #29 was issued a new smoking apron and the licensed nurse completed a new smoking assessment. The resident was educated by the unit manager on not having lighting materials on their person and not lighting other residents' cigarettes. The resident will use a smoking holder to prevent their cigarette from resting on their smoking apron. The 6 cigarette butts on the bushes were removed on 7/2/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | 2. All residents who smoke have the potential to be affected. All residents who currently smoked were evaluated by a licensed nurse on 7/2/2024, and had a new smoking assessments completed, were checked to ensure they did not have lighting materials on them and were educated on the smoking policy.<br><br>3. On 7/1/2024 at 1:00 PM, the Director of Nursing or Nursing Home Administrator or designee began in-servicing all facility staff on the smoking policy. On 7/2/2024 at 3:00 PM, the Director of Nursing or Nursing Home Administrator or designee began in-servicing all facility staff on: Ensuring residents who require close supervision when smoking do not keep their own lighting materials; Ensuring residents do not light other resident cigarettes; Ensure that cigarettes are not resting on anything including smoking aprons; Disposing ashes in the smoking receptacle; Ensuring cigarettes are only extinguished in the smoking receptacle; Ensuring residents do not keep their lighting materials on their person; Ensuring ashes and cigarettes are not disposed of in the bushes; If burn holes are observed on resident clothing to immediately notify the nursing supervisor, Director of Nursing (DON) or the LNHA; Two staff members will be assigned to supervise each smoking time; Staff will be in-serviced prior to starting their assignments.<br><br>4. The Director of Nursing or Nursing home Administrator or Designees will observe the residents and staff during one smoke break daily to ensure that the current policy is being followed. This audit will be conducted once a day- weekly for four weeks, then bi-weekly X four weeks, and then monthly X one month. Findings of the audits will be reviewed by the Quality Assurance Committee at the monthly QAPI meetings X three months.<br><br>The survey team verified the removal plan on-site and the IJ was removed on 7/3/2024 at 1:16 PM.<br><br>The evidence was as follows:<br><br>Reference: Review of the manufacturer specification for the smoking apron [brand name redacted] included: Warning, the webbing closure around the neck and binding around the circumference of the apron is fire rated CA 117 and will melt/self-extinguish when exposed to ash or flame. Both of these components are not certified NFPA 701. Reference: https://www.nfpa.org/codes-and-standards/nfpa-701-standard-development/701. This standard establishes test methods to assess the propagation of flame of various textiles and films under specified fire test condition.<br><br>Review of the facility policy for Resident Smoking, dated/revised, 7/17/23, reflected under policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Policy Explanation and Compliance Guidelines included the following: 6. Residents who smoke will be further assessed using an assessment to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. 10. All safe smoking measures will be documented on each residence care plan and communicated to all . supervision will be provided as indicated on each resident's care plan and subsection. 13. Smoking materials of the residents requiring supervision while smoking will be maintained by nursing staff.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 06/27/24 at 11:14 AM, a surveyor toured the activity room and observed a patio door that led to a balcony that residents utilized for smoking. There was an obstructed view of the smoking area from the activity room and the surveyor observed a table inside the room that contained a box with several cigarette packages and no lighter. The Activity Director (AD) was present and stated she held the cigarettes but did not have a lighter, she stated that some residents had their own lighter and identified Resident #72 as having a lighter. The AD stated she was unable to get the lighter and it was hard to manage Resident #72. The AD stated Resident #72 lit cigarettes for other residents.<br><br>On 7/1/24 at 9:33 AM, during an interview with the surveyor, a Licensed Practical Nurse (LPN) confirmed Resident #29 smoked cigarettes. The LPN stated that the assigned Certified Nursing Assistant (CNA) would walk the resident to the designated smoking area and leave the resident with the recreation staff who monitored the residents smoking.<br><br>On 7/1/24 at 11:03 AM, the surveyor observed Resident #29 seated on a wheelchair holding their smoking apron. CNA #1 then pushed Resident #29's wheelchair through the hallway and into the dayroom.<br><br>On 7/1/24 at 11:06 AM, the AD, who was standing next to the sliding door entrance of the smoking area, provided one cigarette to Resident #29. CNA #1 then continued to push the resident's wheelchair past the glass sliding door, past the other smoking residents, towards the end of the patio where Resident #39 was standing. Resident #39 was then observed using a lighter to light Resident #29's cigarette in the presence of the CNA #1. At that time, CNA #1 exited the smoking area and the day room and the AD remained inside the activity room. Another resident (unsampled resident) smoked along with Residents #29 and Resident #39. All three residents were observed smoking while the activity staff was inside the activity room and no staff were observed in the smoking area monitoring the residents. The smoking area was a lengthwise porch that had two sets of windows divided by a small brick wall that protruded and was on a balcony with bushes in front. All areas were not visible from inside of the activity room.<br><br>On 7/1/24 at 11:08 AM, two activity staff were then observed inside the activity room looking outward. One of the staff was observed looking through the glass sliding door while the other staff observed through the first set of windows adjacent to the sliding door and was looking outward into the smoking area while the residents smoked their cigarettes.<br><br>At that time, during an interview with the surveyor, the activities director (AD) stated they normally remained inside the facility activity room (dayroom), and watched the cigarette smoking residents who were outside the patio. At that time, the surveyor and the AD observed Resident #29's right hand that was holding their cigarette was visibly shaking and then rested their cigarette on their smoking apron. Resident #29 then picked the cigarette up from the smoking apron and continued to smoke.<br><br>At that time, the AD informed the surveyor that Resident #29 usually smoked without anyone around and that Resident #29 normally would drop the ashes from their cigarette onto their smoking apron. The AD was unsure if she had informed anyone about the resident dropping the ashes on the smoking apron. The AD stated that if a resident could smoke, they should be able to manage their cigarette.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 7/1/24 at 11:12 AM, the surveyor and the AD observed CNA #1 who had returned to the smoking area during the interview with the AD, remove Resident #29's smoking apron from the resident and then disposed the cigarette ashes from the smoking apron over the balcony and directly onto the bushes below. At that time, Resident #39 was observed leaving the smoking area and was then pushing Resident #29's wheelchair passed the activity staff and exited the dayroom. The activity staff did not request the lighter that Resident #39 used to light Resident #29's cigarette.<br><br>On 7/1/24 at 11:17 AM, the surveyor observed the cigarette boxes in a container next to the recreation staff and the container did not have a lighter. At that time, the recreation staff confirmed Resident #39 had a lighter. The AD confirmed that the activity staff had not asked for the lighter to be returned to the activity staff when the resident re-entered the facility from the smoking area. The AD stated that the residents blow up and get nasty when asked for the lighter and that she previously communicated this to the unit manager and the Director of Nursing.<br><br>The surveyor reviewed the medical record for Resident #29.<br><br>According to the resident's Admission Record (AR), Resident #29 had diagnoses which included but were not limited to; contracture (fixed tightening of the muscle) of the right elbow, wrist and hand, contracture of the left wrist and hand, paraplegia (paralysis of the legs and lower body), bipolar disorder, major depressive disorder, and anxiety.<br><br>A review of Resident #29's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 6/7/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #29's cognition was intact. Additionally, the resident's functional range of motion for upper and lower extremities were impaired on both sides.<br><br>A review of Resident #29's individualized Care Plan (CP) reflected that the resident liked to smoke. Interventions initiated on 5/31/24, included close monitoring while smoking in the smoking area, observe clothing and skin for signs of cigarette burns, supervised smoking and staff to light/extinguish cigarettes.<br><br>On 07/01/24 at 12:21 PM, LPN #1 provided Resident #29's most recent smoking assessment dated [DATE]. The assessment revealed: Resident #29's ability to hold and handle smoking/tobacco/nicotine product was fair, weak grip, and shaky. The resident needed direction in safety awareness and disposal of ashes in the ashtray and in extinguishing a cigarette. Resident #29 took medications with adverse reactions that affected awareness, judgement, and safety. The resident was documented to have had a smoking related burn in the past six (6) months and required supervision. The determination score was 5 out of 10 which indicated no supervision per the document. The additional comments section contradicted the score and included the resident required a smoking apron, someone to light/extinguish cigarette and supervision included retrieval.<br><br>The surveyor reviewed the medical record for Resident #39.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | According to the AR Resident #39 had diagnoses which included, but were not limited to, cognitive communication deficit (difficulty with aspects of communication/conversation), autistic disorder (a disorder that affects interaction with others involving communication, learning and behavior), Tourette Syndrome (a neurological disorder that may cause sudden unwanted and uncontrolled rapid and repeated movements or vocal sounds), schizoaffective disorder (mental health problem marked by psychosis and mood symptoms), bipolar disorder (a mental illness with extreme mood swing), anxiety disorder and insomnia.<br><br>A review of Resident #39's most recent quarterly MDS, dated [DATE], reflected that the resident had a BIMS score of 14 out of 15, which indicated that Resident #39's cognition was intact. Additionally, the resident's activities for daily living required setup or clean up assistance where in the resident completed the activity and the helper assisted prior to or following the activity.<br><br>A review of Resident #39's individualized CP reflected that the resident liked to smoke and had a potential for injury. Interventions included, close monitoring while smoking in the smoking area, ensure that there is no lighter/ cigarette at bedside; staff will provide such during smoking time in the smoking room. Monitor for compliance with smoking policy and to notify the charge nurse immediately, when the resident was suspected of violating facility smoking policy, initiated on dated 12/10/2020.<br><br>Further review of the resident's CP included another focus area that reflected the resident had schizoaffective disorder, Tourette's, depression, anxiety and received psychotropic medication to help manage symptoms. Interventions included give anti-anxiety medication ordered by physician, monitor, document side effects, and effectiveness. Anti-anxiety side effects included, impaired thinking, judgement, memory loss, forgetfulness. Paradoxical side effects included hostility rage, aggressive or impulsive behavior and hallucinations initiated on 2/6/22.<br><br>A review of Resident #39's most recent smoking assessment dated [DATE], contained the Resident's ability to hold and handle smoking/tobacco/nicotine product was good. The resident's safety awareness, ability to dispose of ashes in the ashtray and in extinguishing a cigarette were documented as good. The resident took medications affecting awareness, judgement and safety but had no adverse effects and in the past 6 months and had no smoking related burn. The determination score was one (1) out of 10 which indicated no supervision was required for the resident. The smoking assessment did not address the resident's ability to utilize a lighter or utilize the lighter to light other resident's cigarettes.<br><br>The surveyor reviewed the medical record for Resident #72.<br><br>According to the AR, Resident #72 had diagnoses which, included but were not limited to; unspecified dementia (impaired ability to remember, think, or make decisions that interfere with completing everyday activities), unspecified severity with anxiety, schizoaffective disorder, and anoxic brain damage (damage to the brain that occurs from oxygen deprivation).<br><br>A review of Resident #72's most recent quarterly MDS dated [DATE], reflected that the resident had a BIMS score of 14/15, which indicated that Resident #72's cognition was intact. Additionally, the resident was independent for activities for daily living and had one incident of a fall.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | A review of Resident #72's individualized CP reflected that the resident liked to smoke, with a potential for injury. Interventions initiated on 9/15/21, included close monitoring while smoking in the smoking area, monitor for compliance with smoking policy and to notify charged nurse immediately if the resident is suspected to violate facility smoking policy.<br><br>Further review of the CP reflected the resident was at risk for falls initiated on 9/15/24, and was related to deconditioning, history of multiple falls impaired balance and mobility. Poor safety awareness due to cognitive decline and use of psychotropic medications. Interventions included to anticipate resident's needs.<br><br>Additionally, the resident can be non-compliant with medication administration, wound treatment, other treatment, safety, daily care needs and hygiene needs. Cognitive impairment, denial of illness, and of risk factors. Interventions included inform the resident, family and caregiver about the risk associated with noncompliance initiated, on 4/1/24.<br><br>A review of Resident #72's most recent smoking assessment dated [DATE], contained the Resident's ability to hold and handle smoking/tobacco/nicotine product was good. The resident's safety awareness required direction. The Resident's ability to dispose of ashes in the ashtray and in extinguishing a cigarette were documented as good. Resident #72 took medications with adverse reactions that affected awareness, judgement, and safety and in the past six months had no smoking related burns. The determination score was 3 out of 10 which indicated no supervision was required for the resident.<br><br>The surveyor reviewed the medical record for Resident #87.<br><br>According to the resident's AR, Resident #87 was a Long Term Care resident at the facility and had diagnoses which included but were not limited to; generalized muscle weakness, unspecified dementia, with other behavioral disturbances, schizoaffective disorder, and anxiety.<br><br>A review of Resident #87's most recent quarterly MDS dated [DATE], reflected that the resident had a BIMS score of 3 out of 15, which indicated that Resident #87's cognition was severely impaired. Additionally, the resident required setup or cleanup assistance for eating and oral hygiene, supervision or touch assistance with toileting, upper body dressing and personal hygiene, partial/ moderate assistance for shower be thing lower body dressing and putting on or taking off footwear.<br><br>A review of Resident #87's individualized CP reflected that the resident like to smoke. Interventions included assess resident's ability to smoke independently/safely, monitor for compliance with smoking policy and notify charge nurse immediately if resident is suspected to violate facility smoking policy.<br><br>Further review of the CP, reflected the resident was at risk for falls related to use of psychotropic medications, poor safety awareness and muscle weakness. Interventions include monitor adverse effects of medications, encourage use of hearing aid and eyeglasses. Additionally, Resident #87 was at risk for elopement with opportunity. Interventions included supervision while outside, initiated on 5/10/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | A review of Resident #87's most recent smoking assessment dated [DATE], contained the Resident's ability to hold and handle smoking/tobacco/nicotine product was good. The resident's safety awareness, ability to dispose of ashes in the ashtray and in extinguishing a cigarette were documented as good. The resident took medications affecting awareness, judgement and safety but had no adverse effects and in the past six months had no smoking related burns. The determination score was one 1 out of 10 which indicated no supervision was required for the resident.<br><br>The surveyor reviewed the medical record for Resident #32.<br><br>According to the AR, Resident #32 had diagnoses which included, but were not limited to; seizures, depression, malignant neoplasm of anterior surface of epiglottis (cancer of the flap that covers the trachea during swallowing so that food does not enter the lungs).<br><br>A review of Resident #32's most recent quarterly MDS dated [DATE], reflected that the resident had a BIMS score of 8 out of 15, which indicated that Resident #32's cognition was moderately impaired. The resident required supervision or touching assistance for eating, substantial maximal assistance for oral hygiene, toileting, upper body dressing, lower body dressing, putting on or taking off footwear and personal hygiene, and was dependent for shower and bathing. The resident had functional limitation and range of motion for upper extremity (shoulder, elbow, wrist, and hand).<br><br>A review of Resident #32's individualized CP reflected that the resident liked to smoke, potential for injury. Interventions initiated on 2/2/24 included close monitoring while smoking in the smoking area, ensure that there is no lighter cigarette at bedside; staff will provide such during smoking time in the smoking room. Monitor for compliance with smoking policy. Notify charge nurse immediately if resident is suspected to violate smoking policy. Observe clothing and skin for signs of cigarette burns. Smoke apron worn while smoking.<br><br>A review of Resident #32's most recent smoking assessment dated [DATE], revealed that the Resident's ability to hold and handle smoking/tobacco/nicotine product was fair, weak grip, and shaky. The resident's safety awareness was poor and the ability to dispose of ashes in the ashtray and in extinguishing a cigarette was also poor and the resident's eyesight was impaired. Resident #32 took medications that affected awareness, judgement, and safety with no adverse effects. The resident was documented to not have had a smoking related burn in the past 6 months. The determination score was five out of ten which indicated no supervision. However, according to the instructions of the smoking assessment the tabulation was the addition of questions 3 to 8 in which the sum was 6 (excluding section 7, wherein the medication had no adverse effect). According to the smoking assessment instructions a total score of 6 or greater would be at risk and needed supervision when smoking. Additional comments included, the resident required a smoking apron, someone to light/extinguish cigarette and supervision per policy.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 7/2/24 at 10:01 AM, during an interview with two surveyors the Licensed Practical Nurse/Unit Manager (LPN/UM) stated everyone who smoked had a smoking assessment conducted by nursing. The assessment included the ability of the resident to hold their cigarette or if extra precaution was needed to see if they needed assistance in holding their cigarette. The LPN/ UM also stated that residents do not hold or keep their cigarettes and lighters. During the day shift the recreation staff helped with monitoring the smoking residents. The LPN/UM stated on the night shift a CNA who worked the 3:00 to 11:00 PM, shift would monitor. The LPN/UM stated, there was no definitive assignment, it was whoever was available. The LPN/UM stated the person assigned to monitor was responsible to provide a cigarette, lighter, monitor, assist when needed, watch the residents ensure that all are safe and that residents were smoking in a safe manner. Each resident who needed an apron had their own. Nursing would let activity staff know about the resident's assessment. The LPN/ UM stated she was not sure how the cigarettes were supposed to be lit. The surveyor asked who was responsible to oversee the smoking program and the LPN/ UM replied, I'm assuming the DON. The LPN stated that residents who experienced a smoking related burn should be reassessed, reevaluated with new safety precautions in place. Accidents should be documented by having a new assessment, a nursing note. and the physician should be informed. The LPN/ UM continued and stated that any staff should intervene and ensure that another resident does not light another resident's cigarette but was not sure how cigarettes should be lit. The LPN/UM stated that a resident deemed shaky and not able to hold their own cigarette would need assistance then staff would need to hold on to their cigarette.<br><br>On 7/2/24 at 10:34 AM, the surveyor asked Resident #29 for permission to view their smoking apron and the resident was agreeable. The front of the smoking apron was visibly dark brown in the medial part with defined roundish cinder type marks and two visible tears. The reverse side of the smoking apron was a lighter brown, deeper darkening in the middle, less cylindrical cinder type marks and two visible tears on the same area.<br><br>On 7/2/24 at 10:52 AM, in the presence of two surveyors, CNA #1 confirmed Resident #39 lit Resident #29's cigarette. The CNA stated they did not know if that was the usual process because she had usually dropped them off. I realized activities [staff] were not outside that is why I went back outside. I saw them putting cigarette on their apron, I did not think that was safe. The CNA stated she told her unit manager and the Administrator (LNHA).<br><br>On 7/2/24 at 11:01 AM, in the presence of two surveyors, Resident #72 was observed lighting Resident #29's cigarette with a lighter.<br><br>On 7/2/24 at 11:06 AM, the surveyors observed Resident #72 exit the smoking area and returned into the facility.<br><br>On 7/2/24 at 11:06 AM, during an interview with the activity staff who was standing next to the sliding doors and while looking out toward the smoking area, she stated that Resident #72 always lit the resident's cigarette. I gave them the lighter, and they lights all the smoker residents' cigarettes. At that time, the activity staff confirmed that she had not taken the lighter back from Resident #72 yesterday. During a subsequent interview with two surveyors, the activity staff stated that she had given Resident #72 the cigarette lighter and Resident #72 would light all the smoking resident's cigarettes, Resident #72 always does. The activity staff confirmed she did not retrieve the lighter from Resident #39 yesterday.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 7/2/24 at 11:16 AM, in the presence of the survey team, the LNHA stated that when a resident passed their smoking assessment the resident was able to light their own cigarette and they should not light another resident's cigarette, we should be doing it. The LNHA stated that there was a three-tier process for those who do not follow the smoking policy which can lead to revoked smoking privileges. I have not had anyone initiated that I can recall since I was here, for 6 months. After surveyor inquiry, the LNHA stated he had confiscated two lighters yesterday from Resident #22 and #72 and asked the two residents randomly. The LNHA confirmed he had no prior knowledge before 07/01/24 that residents held their own lighters and that staff allowed the residents to light their own cigarettes. The LNHA stated he was glad it was brought to his attention since he was not aware of residents lighting other residents' cigarettes or holding their own lighters and informed the surveyors that he would start an investigation.<br><br>On 7/2/24 at 12:12 PM, during an interview with two surveyors, Resident #72 stated I was doing it all the time and was told twenty minutes ago by the UM/LPN that they can't light the cigarettes for the smoking residents anymore.<br><br>On 7/02/24 at 12:16 PM, during an interview with two surveyors, Resident #29 informed the surveyors that his/her cigarette was usually lit by the aide and Resident #72 and they did not have a lighter. The resident stated that had not burned himself but sometimes an ember may fall off and cause a small burn. Resident #29 stated that sometimes staff, and other residents helped him/her but I usually smoke by myself.<br><br>On 7/02/24 at 12:36 PM, during an interview with two surveyors, the housekeeping staff (HK) stated he/she observed burn holes on Resident #29's pants and believed the apron had holes and was burnt through. The HK staff also stated that Resident #32 also had holes on his/her pants and shirt.<br><br>On 7/02/24 12:53 PM, the two surveyors observed six cigarette butts in a bush located immediately in-front of the smoking patio. No fire extinguisher was observed.<br><br>On 7/2/24 at 1:27 PM, in the presence of the survey team, the LNHA stated he had met with all 17 smokers to check if they had cigarette lighters. The LNHA also stated that the residents no longer had cigarette lighters in their possession and he has heard the concerns presented by the survey team and fully investigated the matter.<br><br>On 7/8/24 at 3:10 PM, during a meeting with the survey team, and the Administrator in Training (AIT) and the LNHA did not provide any further information which included an investigation.<br><br>NJAC 8:39-27.1(a), 31.6(e)(2) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>Based on interview, record review and review of pertinent documents it was determined that the facility failed to ensure the facility followed-up regarding resident goals and preferences regarding nutrition, and to ensure a comprehensive nutritional assessment accurately reflected resident goals. The deficient practice was evidenced for 1 of 1 resident reviewed for receiving nutrition via a tube (Resident #75) and was evidenced by the following:<br><br>Reference<br><br>It is the position of the Academy of Nutrition and Dietetics that all Americans aged [AGE] years and older receive appropriate nutrition care; have access to coordinated, comprehensive food and nutrition services; and receive the benefits of ongoing research to identify the most effective food and nutrition programs, interventions, and therapies. Health, physiologic, and functional changes associated with the aging process can influence nutrition needs and nutrient intake. The practice of nutrition for older adults is no longer limited to those who are frail, malnourished, and ill. The population of adults older than age [AGE] years includes many individuals who are living healthy, vital lives with a variety of nutrition-related circumstances and environments. Access and availability of wholesome, nutritious food is essential to ensure successful aging and well-being for the rapidly growing, heterogeneous, multiracial, and ethnic population of older adults. To ensure successful aging and minimize the effects of disease and disability, a wide range of flexible dietary recommendations, culturally sensitive food and nutrition services, physical activities, and supportive care tailored to older adults are necessary. National, state, and local strategies that promote access to coordinated food and nutrition services are essential to maintain independence, functional ability, disease management, and quality of life. Those working with older adults must be proactive in demonstrating the value of comprehensive food and nutrition services. To meet the needs of all older adults, registered dietitians and dietetic technicians, registered, must widen their scope of practice to include prevention, treatment, and maintenance of health and quality of life into old age. Journal of the Academy Nutrition and Dietetics. 2012;112:1255-1277.<br><br>On 06/27/24 at 10:49 AM, a surveyor interviewed resident #75 regarding nutrition while an enteral (nutrition that bypasses the mouth and is delivered via a tube directly into the stomach) nutrition product was being administered. The resident stated that he/she asked the nurse about receiving food and stated, I'm ready for food. Resident #75 stated that the Veteran's Administration took the test for feeding and I'm ready for it, and I passed the test.<br><br>On 07/02/24 at 10:50 AM, the surveyor reviewed a Nutrition Note dated 6/27/2024 at 13:48 [1:45 PM]. The note revealed:<br><br>Note Text: Resident continues to be followed by wound care + NPO [Nothing by Mouth], dependent on tube feeding.<br><br>PMHx: acute respiratory failure, quadriplegia, severe protein calorie malnutrition, glaucoma, embolism, sepsis r/t pseudomonas, HTN, HLD, hypothyroidism, anemia, PTSD.<br><br>NUTRITION STATUS:<br><br>(continued on next page) |

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| | 315047 | A. Building<br>B. Wing | 07/15/2024 |

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| Wynwood Rehabilitation and Healthcare Center | 1700 Wynwood Drive<br>Cinnaminson, NJ 08077 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Jevity 1.5 @70ml/hr for TV 1260mL provides:<br><br>H2O flush 300mLq6 hrs for TV 1200 mL<br><br>Liquid Protein 30mL QD via pump provides 70 kcal + 16g protein<br><br>In total provides:<br><br>1960 kcal<br><br>96.4 g protein<br><br>2158 ml free water, not including med flushes<br><br>Increased needs [result to] r/t unchanged wound healing, low BMI [body mass index] + wt [weight] stable. May benefit from modest increase to meet mid range of kcal needs. RD met w/ res [resident]who denies n/v, c/d and is agreeable to increase. RD called family to make aware as well. No questions/concerns at this time. Res may also benefit from mod to vit/min supps to further support wound healing.<br><br>GOALS:<br><br>Resident would benefit from gradual wt gain toward BMI > 20<br><br>Continued toleration to TF regimen<br><br>Maintain adequate hydration<br><br>TF regimen to support improvement of wound status as able<br><br>INTERVENTIONS:<br><br>1) Rec update TF rate + TV as follows: Jevity 1.5 @ 80mL/hr for TV 1400 daily; reduce flush to 250mL q6 hrs for TV 1000mL daily + liquid protein supplement, provides:<br><br>2170 kcal<br><br>105.3g [grams]protein<br><br>2064 ml fluid (not including med flush)<br><br>2) Rec continue ascorbic acid 500mg x30 days, rec [recommend] zinc sulfate 220mg x30 days; continue MVI [multivitamin with ] c minerals<br><br>3) Monitor TF toleration, wts + labs as available. POC [plan of care] updated; continue POC.<br><br>Assessment & Plan<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Has history of PEG [percutaneous endoscopic gastrostomy tube that provides food into the stomach) and is on Jevity 1.5 at 55 mL x 18 hours 4p to 10a, 752 free water, free water<br><br>flush 320 mL every 8 hours total volume 960 mL per 24 hours.<br><br>-Family also states is allowed pleasure feed daily with 1 cup of yogurt.<br><br>A review of the Order Summary Report for all orders active as of 06/01/2024 revealed the Diet Order for NPO diet NPO texture, NPO consistency, for Diet remained in place.<br><br>The Care Plan revealed a Focus:<br><br>I have a nutritional problem or potential<br><br>nutritional problem (enteral feeding,<br><br>multiple wounds, NPO diet currently, low<br><br>BMI/weight), high risk for aspiration<br><br>Date Initiated: 05/17/2024<br><br>Revision on: 05/17/2024<br><br>Target Date: 10/13/2024<br><br>Interventions: Provide and serve diet as ordered: NPO [nothing by mouth]<br><br>TF[tube feeding] as sole source of nutrition & hydration. Jevity 1.5 @ 80ml [milliliter]/hr TV [total volume] 1400ml with<br><br>250ml water flush Q [every] 6H 1000ml TV<br><br>Date Initiated: 05/17/2024<br><br>Revision on: 06/27/2024<br><br>Diet<br><br>Provide and serve supplements as ordered: Protein liquid QD [daily]<br><br>Date Initiated: 05/17/2024<br><br>Revision on: 06/27/2024<br><br>RD to evaluate and make diet change recommendations PRN.<br><br>Date Initiated: 05/17/2024<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Revision on: 05/17/2024<br><br>The Care Plan did not address the resident's wishes or history of consuming pleasure feedings.<br><br>On 07/03/24 at 10:31 AM, the surveyor interviewed the facility Registered Dietitian (RD) regarding Resident #81. The surveyor asked if the RD met with Resident #81 as she indicated she was at the facility three days per week. The RD stated that she increased Resident #81's tube feeding due to wounds.<br><br>The interview continued and the surveyor asked if the RD reviewed hospital records and progress notes also, and she had confirmed that she did. The RD confirmed that she met with Resident #81 and he/she asked about NPO status, but the RD stated he/she was agreeable for increasing the tube feeding as it may be beneficial for nutrition for wound healing and the resident was agreeable. The RD stated the resident had aspirated many times, and confirmed the resident had pleasure meals at one point. The RD stated she asked about the diet to the speech therapist and confirmed she did not review any swallowing studies if they were available. The surveyor asked if the RD communicated with the physician regarding the resident's request and the RD stated, I have not spoken with the physician. The surveyor asked if the pleasure feedings were discussed with the interdisciplinary team and the RD stated it was and it is not documented. The surveyor asked about any documentation from the speech therapist and the RD stated she spoke with the speech therapist and it was not documented. The RD confirmed that there was no rationale why the resident was not receiving the pleasure feeding and was not documented as part of the nutrition assessment.<br><br>On 07/08/24, the Facility Licensed Nursing Home Administrator (LNHA) provided a copy of a Speach Therapy Evaluation, dated 05/01/24 from the Veterans Administration (VA) which revealed Recommendations: 1. NPO with PEG tube for nutrition/hydration, 3. Refer for Modified Barium Swallow Study (uses an x-ray with barium in foods to determine ability to swallow). A type written timeline provided by the facility revealed that upon the resident's discharge on 05/17/24, oral trials were ultimately deferred at this time until swallow study can be scheduled through the VA. As of 07/05/24 we are still waiting for the VA to schedule the swallow study.<br><br>On 07/08/24 at 1:10 PM, the surveyor informed the nursing home administrator regarding Resident #81's request for pleasure feeding and no documented evidence regarding follow-up on the resident's wishes was provided. The facility was unable to provide the surveyor with any documented evidence regarding the follow up swallowing study.<br><br>The Nutritional Management Policy, revised 04/09/24 revealed 5. Monitoring/revision: e. Nutirional recommendations made by the dietitian based on the resident's preferences, goals, clinical condition or other factors and followed up with the physician/practitioner for orders as per facility policy.<br><br>NJAC 8:39-27.1(a) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>48422<br><br>Complaint #167264<br><br>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:<br><br>Refer to 600 K and 677F<br><br>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.<br><br>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).<br><br>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.<br><br>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<br><br>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.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>At 6:45 AM, surveyor #1 and the CNA observed Resident #41 in bed and was saturated in urine.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The following ratio(s) were effective on 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>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<br><br>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.<br><br>Staffing had been calculated for the following time frames and revealed the following:<br><br>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:<br><br>-06/25/23 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -06/29/23 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.<br><br>-06/30/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs.<br><br>-07/01/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.<br><br>-07/02/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs.<br><br>-07/08/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs.<br><br>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:<br><br>-07/30/23 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs.<br><br>-08/05/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs.<br><br>-08/06/23 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs.<br><br>-08/07/23 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.<br><br>-08/12/23 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs.<br><br>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:<br><br>-11/19/23 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.<br><br>-11/25/23 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.<br><br>-11/26/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs.<br><br>-11/27/23 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.<br><br>-11/29/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.<br><br>-11/30/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs.<br><br>-12/02/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs.<br><br>-12/03/23 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.<br><br>-12/07/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs.<br><br>-12/09/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs.<br><br>-12/10/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -12/12/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs.<br><br>-12/16/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.<br><br>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:<br><br>-06/15/24 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs.<br><br>-06/16/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs.<br><br>-06/21/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.<br><br>-06/22/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs.<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>NJAC 8:39-4.1 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449<br><br>Based on observation, interview, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a.) prescription medications were labeled and accounted for, b.) expired supplies were identified and removed from active inventory, c.) supplies that required dating were dated and d.) to consistently maintain accurate administration, reconciliation, and accountability of dispensed controlled dangerous substance (narcotic medication) stored within the electronic back-up machine (EBM).<br><br>This deficient practice was identified for one (1) of two (2) medication rooms, two (2) of eight (8) medication carts and one (1) of one (1) EBM inspected for the medication storage and labeling.<br><br>The evidence was as follows:<br><br>Reference:<br><br>21 CFR 1306.24(b)<br><br>If the prescription is filled at a central fill pharmacy, the central fill pharmacy shall affix to the package a label showing the retail pharmacy name and address and a unique identifier, (i.e. the central fill pharmacy's DEA registration number) indicating that the prescription was filled at the central fill pharmacy, in addition to the information required under paragraph (a) of this section.<br><br>21 CFR 205.50(a)(3)<br><br>a) Facilities. All facilities at which prescription drugs are stored, warehoused, handled, held, offered, marketed, or displayed shall:<br><br>Have a quarantine area for storage of prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated, or that are in immediate or sealed, secondary containers that have been opened .<br><br>1.) On [DATE] at 10:23 AM, in the presence of the Licensed Practical Nurse (LPN #1) the surveyor began the medication room inspection located in the South wing.<br><br>At 10:16 AM, during the inspection of the back-up over the counter medication stored in the medication room the surveyor observed an undated, unlabeled, prescription medication, Lidocaine Prilocaine 2.5%/2.5% Cream (indicated for local anesthesia).<br><br>At that time, the LPN #1 stated that prescription medication should have been delivered with a label even if it was for back-up use. The LPN also stated that she would remove the item, inform the Unit Manager (UM) and give the UM the item.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2.) At 10:31 AM, the surveyor and the LPN #1 observed the following expired supplies in the medication room:<br><br>-one (1), 3ml syringe with hypodermic safety needle 21gauge x 1 inch, with an expiration date of [DATE].<br><br>-two (2) luer lock disposable syringe without safety needle 30ml, one (1) of which had a brownish/red stain on the packaging, with an expiration date of [DATE].<br><br>-nine (9) Insyte Autoguard needles 22gauge x 1 inch, with an expiration date of [DATE].<br><br>-two (2) Insyte Autoguard needles 22gauge x 1 inch, with an expiration date of [DATE].<br><br>-one (1) Insyte Autoguard needles 22gauge x 1 inch, with an expiration date of [DATE].<br><br>At that time, the LPN #1 informed the surveyor that the luer lock disposable syringe without safety needle 30ml was used to flush, and administer medications to residents who had a PEG tube (percutaneous endoscopic gastrostomy; feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall).<br><br>At that time, the LPN stated that she would remove the expired supplies and inform the UM.<br><br>3.) On [DATE] at 11:23 AM, in the presence of LPN #2, the surveyor began the medication cart inspection of cart #2, located on the North wing.<br><br>At 11:27, the surveyor and LPN #2 observed an opened blood glucose (bg) test strip bottle (used with a glucometer to provide immediate reading of blood sugar, or glucose level). The packaging indicated use within 6 months after first opening).<br><br>At that time, LPN #2 confirmed the bg test strip bottle should have been dated. LPN #2 stated she had opened the bottle last night but forgot to date the bottle.<br><br>On [DATE] at 11:46 AM, in the presence of LPN #3, the surveyor began the medication cart inspection of cart 1, located on the North wing.<br><br>At that time, the surveyor and LPN #3 observed an opened bg test strip bottle.<br><br>At that time, LPN #3 confirmed the bg test strip bottle should have been dated, to know the 6-month period from the time the bottle was opened.<br><br>At that time, LPN #3 stated she would discard the opened, undated bg test strip bottle and would inform her UM.<br><br>4.) On [DATE] at 2:51 PM, during the inspection of the EBM, in the presence of the North UM and the Director of Nursing (DON), the surveyor observed the Back-Up Controlled Substance Administration log of Zolpidem 5mg (indicated for insomnia) had two (2) doses removed on [DATE] at 9:00 PM for Resident #27.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At that time, the DON informed the surveyor that the nurse on that shift had removed two doses of the Zolpidem 5 mg.<br><br>At that time, the surveyor and the DON reviewed the electronic Medication Administration Record (eMAR) together. Resident #27's Order Summary Record, did not reflect and order for Zolpidem 5 mg but did have an order for the Zolpidem 10 mg.<br><br>Further review of the eMAR reflected the administration was signed on [DATE] instead of [DATE].<br><br>At that time, the surveyor asked the DON if there was an investigation or an incident report regarding the administration of Zolpidem 5mg without a physician's order.<br><br>At that time, the DON stated she would get back to the surveyor.<br><br>On [DATE] at 9:15 AM, during a follow -up interview with the surveyor, the DON stated that the accountability for discrepancies was the responsibility of the UM, Supervisors and herself,<br><br>At that time, the surveyor asked the DON why the discrepancy was identified on [DATE], during the medication inspection, instead of when it occurred on [DATE] or the day after [DATE].<br><br>At that time, the DON stated that it had occurred on the weekend and that she would have discovered the error that Monday on [DATE].<br><br>At that time, the DON acknowledged that a UM or a Supervisor was on staff but was unsure how they received the report on the weekend. The concern was conveyed to the DON regarding the inaccurate administration, dispensing, missing reconciliation for the zolpidem discrepancy.<br><br>On [DATE] at 1:32, the surveyor discussed the concerns regarding the unlabeled prescription medication intermingled with the over-the-counter medication, expired supplies, undated bg test strips and lack of accountability, reconciliation for the administration, and dispensing of zolpidem 5 mg without a physicians' order for Resident # 27.<br><br>No further information was provided.<br><br>A review of the facility policy provided, dated/revised on [DATE],<br><br>Included the following under Policy Explanation and Compliance Guidelines:<br><br>2. Narcotics and Controlled Substances<br><br>c. Any discrepancies which cannot be resolved must be reported immediately as follows:<br><br>ii. Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted.<br><br>iv. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8. Unused medications: the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn illegible, or missing labels.<br><br>NJAC 8:,d+[DATE].4 (a)(c) (g) (k),29.7(c) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>45449<br><br>Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure adequate indication, and a gradual dose reduction (tapering towards an optimal dose) of an antipsychotic medication was attempted annually to establish an optimal dose, for a hemipelagic resident with congestive heart failure (Resident #62).<br><br>This deficient practice was identified for one (1) of five (5) residents reviewed for unnecessary medications and was evidenced as follows.<br><br>Reference:<br><br>A review of the manufacturer's specifications for Seroquel (quetiapine) under the black box warning reflected Warning:<br><br>Increased Mortality In Elderly Patient with dementia related psychosis and suicidal thoughts and behaviors.<br><br>Section 1 Indications and Usage included schizophrenia, bipolar disorder, and special considerations in treating pediatric schizophrenia and bipolar 1 disorder.<br><br>Section 5.1 included, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death .<br><br>Section 5.3 Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis . Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis.<br><br>On 7/3/24 at 10:21 AM, the surveyor entered the resident's room. The resident was observed in bed, the head of the bed was inclined, and the bed was in a low position. Resident #62 spoke in [dialect redacted] and asked the surveyor to come closer.<br><br>On 7/3/23 at 10:23 AM, the Occupational Therapist (OT) entered the room and stated the resident was picked up by rehabilitation for range of motion.<br><br>The surveyor reviewed the medical record for Resident #62.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to the resident's (AR; or face sheet, an admission summary) reflected that that resident was a long-term care (LTC) resident at the facility and had diagnoses which included but were not limited to hemiplegia affecting the right domain side (paralysis of the right side), anemia (condition of the body not having enough healthy red blood cell), chronic diastolic (congestive) heart failure (when the heart is unable to pump enough blood to meet the body's need) , unspecified dementia with other behavioral disturbances, mood disorder (mental illness that affects a person's emotional state or mood), depression and insomnia.<br><br>A review of Resident #62' s most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 6/9/24, reflected that the resident had impaired vision that required corrective lenses (contacts, glasses or magnifying glass) and was sometimes understood. The Brief Interview for Mental Status (BIMS) score was 99 out of 15 which indicated the resident was unable to complete the interview. The resident had not exhibited symptoms of delirium or hallucination.<br><br>Further review of the qMDS revealed the resident received an antipsychotic medication without an attempted GDR; According to the qMDS, the physician documented on 5/24/24, that a GDR was contraindicated.<br><br>A review of the resident's most recent individualized Comprehensive Care Plan (care plan) reflected that the resident had impaired cognition/forgetfulness due to a diagnosis of dementia. Interventions included provide consistency with caregivers/routine, reorient as needed and to offer praise and encouragement.<br><br>Further review of the resident's care plan reflected the resident had anxiety, depression, mood disorder and received psychotropic medications to help manage symptoms, dated/revised on 9/20/22. Interventions included consult with pharmacy, and physician to consider dosage reduction when clinically appropriate. Family, not interested in a dose reduction at this time due to my long history of depression, anxiety, mood disorder, dated/revised on 9/20/22. The resident's care plan was not updated since.<br><br>A review of the resident's Order Summary Report for 7/3/24, included a physician's order for Quetiapine (Seroquel) 50 milligram (mg), give 1 tablet by mouth at bedtime for mood disorder with an order date from 9/19/22.<br><br>A review of the resident's monthly Psychoactive Review from 5/15/23 to 6/25/24, did not reflect behaviors exhibited by the resident associated with the physician's order for Seroquel (Quetiapine) 50 milligram for mood disorder.<br><br>A review of the Advance Practical Nurse's Psychiatric Progress Note dated 3/3/23, included that the patient was received lying in bed calm, cooperative during visit, able to answer simple questions and denied depression or anxiety; diagnoses were depression, mood disorder and insomnia.<br><br>The plan consisted of the following:<br><br>1. Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Treat medical issues including pain, UTI, constipation, infection, physical issues, positioning, toileting. Encourage participation in activities, as tolerated and as possible for psychosocial well-being.<br><br>2. continue medication regimen benefit greater than risk.<br><br>3. continue to observe mood, behavior, sleep, appetite, notify psychiatry of any changes<br><br>4. will follow<br><br>-Have considered the risk of and benefit associated with black box warnings.<br><br>Gradual Dose Reduction GDR contraindicated, medically necessary at this time, the benefits outweigh the risk of treatment.<br><br>-contraindicated, a reduction would likely result in an exacerbation/return of serious symptoms.<br><br>-contraindicated, due to noted efficacy and improvement in quality of life with current treatment<br><br>psychiatric medications requiring management/risk assessment (effectiveness/side effects monitored). (moderate).<br><br>A review of the APN-C's Psychiatric Progress Note dated 11/3/23, which included that the resident was doing ok with no behavioral concerns reported by staff. Evaluation is limited due to cognitive deficits; diagnoses were depression, dementia, mood disorder and insomnia.<br><br>The plan consisted of the following:<br><br>1.) to Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including pain, UTI, constipation, infection, physical issues, positioning, toileting. Encourage participation in activities, as tolerated and as possible for psychosocial well-being.<br><br>2. continue medication regimen benefit greater than risk.<br><br>3. continue to observe mood, behavior, sleep, appetite, notify psychiatry of any changes<br><br>4. will follow<br><br>-Have considered the risk of and benefit associated with black box warnings.<br><br>Gradual Dose Reduction GDR contraindicated, medically necessary at this time, the benefits outweigh the risk of treatment.<br><br>-contraindicated, a reduction would likely result in an exacerbation/return of serious symptoms.<br><br>-contraindicated, due to noted efficacy and improvement in quality of life with current treatment<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | psychiatric medications requiring management/risk assessment (effectiveness/side effects monitored). (moderate).<br><br>A review of the APN-C's Psychiatric Progress Note dated 2/2/24, included: As per staff patient doing good with no behavioral problems, evaluation limited due to cognitive status; diagnoses were depression, dementia, mood disorder, mood disorder, insomnia and anxiety.<br><br>The plan consisted of the following:<br><br>1.) to Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including pain, UTI, constipation, infection, physical issues, positioning, toileting. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well-being.<br><br>2. continue medication regimen benefit greater than risk.<br><br>3. will follow<br><br>-Have considered the risk of and benefit associated with black box warnings.<br><br>Gradual Dose Reduction GDR contraindicated, medically necessary at this time, the benefits outweigh the risk of treatment.<br><br>-contraindicated, a reduction would likely result in an exacerbation/return of serious symptoms.<br><br>-contraindicated, due to noted efficacy and improvement in quality of life with current treatment<br><br>psychiatric medications requiring management/risk assessment (effectiveness/side effects monitored). (moderate).<br><br>A review of the APN-C's Psychiatric Progress Note dated 5/24/24, which included that the patient was stable at baseline with no behavior or mood concerns reported by staff; diagnoses were insomnia, dementia, anxiety, and mood disorder.<br><br>The plan consisted of the following:<br><br>1.) to Always consider/implement relevant supportive and non-pharmacological interventions, including redirection, support/reassurance, comfort measures, reduced environmental stimulation, expression of feelings, family involvement. Treat medical issues including pain, UTI, constipation, infection, physical issues, positioning, toileting. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well-being.<br><br>2. continue medication regimen benefit greater than risk.<br><br>-Have considered the risk of and benefit associated with black box warnings.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Gradual Dose Reduction GDR contraindicated, medically necessary at this time, the benefits outweigh the risk of treatment.<br><br>-contraindicated, a reduction would likely result in an exacerbation/return of serious symptoms.<br><br>-contraindicated, due to noted efficacy and improvement in quality of life with current treatment<br><br>psychiatric medications requiring management/risk assessment (effectiveness/side effects monitored). (moderate).<br><br>A review of the Certified Consultant Pharmacist's (CCP) Resident's Evaluation from 6/13/2023 to 5/30/2024, did not reflect recommendation for gradual dose reduction for Seroquel in consideration to the resident's monthly psychoactive review which revealed the resident had no behaviors.<br><br>Further review of the CCP monthly medication review did not reflect a clarification for the indication of Seroquel in which mood disorder was not a manufacturer's indication.<br><br>On 7/3/24 at 1:33 PM, during a meeting with the survey team, the Director of Nursing, the Licensed Nursing Home Administrator, the surveyor discussed the concern regarding the indication, and the missed annual opportunity for gradual dose reduction of Seroquel in the last year of (physician order date of 9/19/22), to ensure the resident received the optimal dose for Resident #62 ,who had no marked behaviors, and no history of schizophrenia or bipolar disorder.<br><br>On 7/8/24 at 9:45 AM, during a telephonic interview with two (2) surveyors, the CCP stated they had taken over the building on 4/2024.<br><br>At that time, the CCP stated that the manufacturer's indications for Seroquel were schizophrenia bipolar and other special considerations.<br><br>At that time, the CCP stated that the Psychiatric Consult dated 5/24/24 reflected that a GDR was contraindicated and because of that she had deferred to Psychiatry and had not recommended a GDR.<br><br>At that time, the CCP stated that even when there were no marked behaviors, she deferred to Psychiatry.<br><br>On 7/8/24 at 11:02 AM, during a telephonic interview with the surveyor, the APN-C stated she was familiar with the resident and had been seeing her since the resident entered the facility.<br><br>At that time, the surveyor asked why the resident was receiving Seroquel with a diagnosis for mood behavior, with consideration to the black box warning, the manufacturer's guideline of indication, and the resident's void of mood behaviors. The APN stated that the reason was the resident had previously failed a GDR but could not indicate the date. The APN stated she would get back to the surveyor. The APN-C also stated that the family was against the GDR.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/8/24 at 11:10 AM, during a telephonic interview with the surveyor, the resident representative stated that she received a call a few days ago and was asked if she wanted the resident to continue or discontinue the use of Seroquel. The patient representative stated that a gradual dose reduction or tapering of Seroquel was not explained to her as an alternative; she did state that the resident was doing good.<br><br>On 7/8/23 at 1:33 PM, the Psychiatrist Medical Doctor (MD) called back instead of the APN-C. During a telephonic interview with the surveyor, the MD stated that they have been a provider for the facility for the last two (2) years. The MD stated that the resident entered the facility with the medication (Seroquel) in 2020 wherein the resident exhibited paranoid delusions, insomnia, and impaired function. Currently the resident is under control and is stabilized and would not want to risk a relapse.<br><br>At that time, the surveyor asked the MD about the black box warning and contraindication, the MD stated that there is no evidence that the medication is problematic, contraindication is due to severe symptoms. We are improving the quality of life in a positive way. The surveyor then asked about the unlabeled usage (indication), since the resident was neither schizophrenic or bipolar, the MD stated the position was that the resident had severe instances is now stable. The surveyor asked how an optimal dose could be achieved without trying a gradual dose reduction. The MD then stated because the resident is under control, we would not want to remove.<br><br>On 7/8/24 at 3:10 PM, in the presence of the survey team, the Licensed Nursing Home Administrator, did not provide a response to the concerns.<br><br>A review of the facility provided policy, Gradual Dose Reduction of Psychotropics dated/revised 4/15/24 under Policy Explanation and Compliance Guidelines included subsection 3. After the first year, a GDR will be attempted annually, unless clinically contraindicated.<br><br>No further information was provided.<br><br>N.J.A.C. 8:39-27.1 (a) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>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:<br><br>Refer to: 600 K, 609D, 610H, 686H, 689L, 725F, 865F<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| | 315047 | A. Building<br>B. Wing | 07/15/2024 |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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).<br><br>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.<br><br>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.<br><br>The evidence was as follows:<br><br>On 6/28/24 at 12:30 PM, the surveyor reviewed the closed medical record for Resident #150.<br><br>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.<br><br>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).<br><br>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.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>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.<br><br>Review of the OSR revealed a PO dated 07/03/23, for a low air mattress. Check placement and functioning every shift.<br><br>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.<br><br>On 11/09/23 (7 days later), indicated No new skin alterations. No measurement was entered on the skin assessment.<br><br>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 extremely which was not identified by staff at the facility.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>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.<br><br>At 6:45 AM, surveyor #1 and the CNA observed Resident #41 in bed and was saturated in urine.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>The facility provided Administrator Job Description updated May 2023 revealed: Major Duties and Responsibilities: Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance wish current state and federal laws and regulations. Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indictors. Establishes and ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility. Evaluates key performance indicator outcomes with department heads to determine the need for action from leadership and/or management such as re-reduction or revisions related to the facility's outcomes, regulatory compliance and/or customer satisfaction. Ensures delivery of compassionate quality care and services across an interdisciplinary team approach as evidenced by adequate, and competent facility staff, employee turnover, general cleanliness, physical plant condition, and optimal resident functioning-physically and psychosocially. Identifies and collaborates with members of the interdisciplinary team, physicians, consultants, and community agencies to identify to identify opportunities for enhanced services to the residents and/or resolve issues. Performs rounds to observe residents and ensure overall needs are being met .<br><br>f.) 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.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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 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.<br><br>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.<br><br>On 07/08/24 at 8:20 AM, the surveyor requested the LNHA to provide all current active QAPI for review with survey team.<br><br>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 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.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>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.<br><br>The surveyor reviewed the QAPI program provided by the LNHA for review and the identified concerns were not addressed in QAPI.<br><br>NJAC 8:39-27.1(a) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>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 Perforamance 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:<br><br>Refer to 600K, 610H, 689L, 686H, and 677F<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>A review of the electronic medical record for Resident #84 revealed (EMR):<br><br>- 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.<br><br>- 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.<br><br>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.<br><br>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).<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>c) On 06/27/24 and 06/28/24 during multiple observations surveyors observed:<br><br>-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.<br><br>- 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.<br><br>-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.)<br><br>- 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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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 Administraation Record (TAR) from 12/1/23 to 12/5/23 indicating that the wound care was completed as ordered.<br><br>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 osteormyelitis. According to nursing notes, patient was admitted for wound infection.<br><br>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:<br><br>Emergency Department (ED) Provider Note dated 12/05/23 at 11:00 revealed:<br><br>-Initial Complaint:<br><br>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.<br><br>The surveyor reviewed the hospital record from the hospitalization of 12/19/23 and the following were noted:<br><br>-Comments: Right lower extremity: Contracture with flexion at the hip and knee. Significant wound on the anterior shin with exposed bone .<br><br>-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 wall 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.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>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.<br><br>On 07/08/24 at 8:20 AM, the surveyor requested the LNHA to provide all current active QAPI for review with survey team.<br><br>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 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.<br><br>(continued on next page) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>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.<br><br>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.<br><br>The surveyor reviewed the QAPI program provided by the LNHA for review and the identified concerns were not addressed in QAPI.<br><br>NJAC 8:39-33.2(a)(b)(c)1,3 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>27193<br><br>Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to minimize the potential spread of infection to residents during medication administration for 1 of 2 nurses observed during the medication pass on 1 of 2 units (North Wing).<br><br>This deficient practice was observed and evidenced by the following:<br><br>On 6/28/24 at 7:00 AM, the surveyor observed signage posted at the entrance door which read: Enhanced Barriers Precautions Stop. Everyone must clean their hands before entering and exiting the room. Providers and suppliers must also wear gloves and gown during high contact Resident Cares activities, or devices care.<br><br>On 06/28/22 at 7:15 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medications for Resident #71. The LPN opened the top drawer of the medication cart, retrieved the glucometer machine, don (put on) gloves and a Personal Protective Equipment (PPE) gown and entered Resident #71's room. The LPN went to the room, informed the resident of the procedure, and checked the resident blood sugar. The LPN exited the room, removed the gloves and gown, disposed of them in the receptacle bin attached to the medication cart, returned to the computer and entered the result. The LPN retrieved a syringe from the medication cart then realized there was no insulin available on the cart for Resident #71. The LPN stated that she needed to go to the medication storage room to obtain the insulin. The LPN went to the storage room and returned with the insulin which was stored in a plastic bag. The LPN returned to the medication cart, prepared and administered the insulin without performing hand hygiene. The LPN exited the room, removed and disposed of the soiled PPE in the receptacle bin, signed for the medication administered and again did not perform hand hygiene.<br><br>At 7:25 AM, the LPN started to check the medication for the resident in the next bed. The LPN donned gloves and a gown in the hallway prior to entering the room. The LPN entered the room, retrieved a device on the resident table and checked their blood sugar. The LPN returned the device to the table, exited the room without performing hand hygiene.<br><br>The LPN returned to the medication cart, removed the soiled PPE and proceeded to prepare medication for the resident. The surveyor observed the LPN did not perform hand hygiene after she removed the soiled PPE. The LPN did not perform hand hygiene before she continued to prepare other medications for administration.<br><br>At 7:25 AM, the LPN entered the resident's room and handed the resident the cup of medication. She then picked up a disposable cup that contained water that was on the overbed table while wearing gloves and handed it to the resident. She removed the gloves in the room, went to the sink and washed her hands. The LPN returned to the medication cart, removed the soiled gown, and did not perform hand hygiene. She returned to the medication cart and utilized the computer, as she signed out the medications that were administered in the electronic medical record.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 7:40 AM, the surveyor interviewed the LPN regarding the signage observed at the entrance of the resident's door. The LPN informed the surveyor that both residents were on Enhanced Barrier Precautions and staff were to don and doff (remove) prior to entering and exiting the room and perform hand hygiene. The surveyor then asked the LPN if she should follow the protocol during medication administration. The LPN stated, I thought that I should perform hand hygiene only when moving from one resident to the other. The surveyor then asked the LPN if she should wash her hands after removing PPE and she stated, Yes, I should have. When asked for the rationale why she should perform hand hygiene after removing soiled PPE, she stated that by not washing her hands or performing hand hygiene prior to and after medication administration, she risked the spread of infection.<br><br>On 06/28/24 at 10:00 AM, the surveyor interviewed the Unit Manager (UM) who stated that staff were required to perform hand washing prior to medication administration and could have used hand sanitizer up to three times before performing hand hygiene with soap and water. He stated that cross-contamination could result if hands were not washed prior to handling medications, the computer keyboard and the medication cart.<br><br>On 06/28/24 at 11:02 AM, the Director of Nursing (DON) provided an in-service education sheet to the surveyor. Upon inquiry, the DON stated that the LPN reported that she omitted to wash her hands during the medication administration pass. The surveyor then interviewed the DON who stated that she expected nursing to wash their hands or use Alcohol Based Hand Rub (ABHR) prior to handling medications, as it was an infection issue if hand hygiene was not performed first. The DON stated that nursing should also sanitize their hands after they left the resident's room, after medication administration, and before they did anything else. She stated that staff were instructed to sanitize their hands after they doffed their gloves to ensure that both staff and residents were safe from infection. The surveyor requested the policy for hand hygiene for review.<br><br>On 07/03/24 at 11:25 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that he expected that nursing would have utilized ABHR in between each resident during medication pass. She stated that nursing was also required to wash their hands prior to donning and after doffing gloves. The IP stated that that cross-contamination could result if hands were not washed prior to handling medications, the computer keyboard and the medication cart.<br><br>The surveyor reviewed the facility policy titled, Hand Hygiene last revised, 5/29/24 which revealed the following:<br><br>All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility.<br><br>Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.<br><br>NJAC 8:39-19.4 (a) |