STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315077	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrooke Court Skilled Care at Evergreens	309 Bridgeboro Rd Moorestown, NJ 08057

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 33106 Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to a.) identify and investigate a bruise of unknown origin and b.) follow interventions implemented on the Care Plan (CP) for a resident identified as having fragile skin. This deficient practice was identified for 1 (one) of 2 (two) residents (Resident #117) reviewed for accidents and was evidenced by the following: The Admission Record dated 06/06/24, indicated that Resident #117 had diagnoses which included, but were not limited to, dementia and major depressive disorder. The quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 04/11/24, indicated that the resident had severe cognitive impairment and required maximum assistance with all aspects of activities of daily living (ADLs). On 06/04/24 at 07:06 PM during tour, the surveyor observed Resident #117 lying in bed with the left arm exposed. The surveyor observed that the resident had a large irregular shaped dark purplish colored bruise noted on the left forearm. The resident was not able to be interviewed due to cognitive deficits. The surveyor also observed that the left-side rail was padded, and the right-side rail was not. On 06/05/24 at 12:12 PM, the surveyor observed Resident #117 lying in bed and was non-verbal. The resident was able to make eye contact with the surveyor. The surveyor observed that both the resident's arms were exposed, and the surveyor visualized a large, irregular shaped, dark, purplish colored bruise on the left forearm and a skin tear with steri-strips (to keep the edges of the wound together as it heals) on the right forearm. The surveyor observed that the left side rail was padded and the side rail on the right side was not padded. The surveyor reviewed the residents Care Plan (CP) which revealed the following documentation: -Focus: That the resident was at risk for skin tear/bruise related to my fragile skin. The focus was initiated on 07/12/2021. The CP reflected an intervention that was initiated on 02/07/2024, that the enabler bars were to be padded to protect the resident's skin. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to the resident requiring hospice services. The surveyor reviewed the nursing Progress Notes (PN), dated 06/04/24 at 08:01 PM, which indicated that a nurse performed a weekly skin assessment and that no new skin abnormality was noted. This skin assessment was performed after the surveyor's first observation of the bruise. There was no documentation in the PN that the resident had a large bruise on the left forearm. On 06/05/24 at 12:12 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the bruise on the resident left forearm was identified a week ago (could not provide a specific date) by the resident's companion from hospice. The CNA stated that the companion from hospice provided care to the resident from 7:00 - 9:00 AM and reported to her that the resident had a bruise on the left forearm. The CNA stated that the companion also told her that she reported the left forearm bruise to the Licensed Practical Nurse (LPN) that was providing care to the resident. On 06/05/24 01:01 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that he was not notified that the resident had a bruise on the left forearm. He stated that the resident did not have a companion but had a hospice CNA that came in for a couple hours each morning to care for the resident. When the surveyor asked LPN #1 about the bruise on the resident's left forearm, the LPN stated that he had not seen the bruise. LPN #1 stated that if a resident had a bruise of unknown origin, then an incident report should have been completed and the bruised area should have been measured and assessed. He continued to add the resident should have been assessed for further injury and an investigation should have been conducted. He explained that during the investigation the nurse would obtain statements from the staff going back three shifts and that the family and primary care physician would have been notified. He then stated that Resident #117 had some behaviors, such as flailing of the arms during care, which could have caused a bruise. On 06/06/24 at 10:06 AM, the surveyor reviewed the resident's medical records and there was still no documentation or assessment documented in the electronic medical record (EMR) regarding the bruise on the residents left forearm. On 06/06/24 at 09:14 AM, the surveyor observed a staff member providing care to Resident #117. The staff member was interviewed and identified herself as the Home Health Aide (HHA) from hospice. The HHA stated that she reported the bruise on the resident's left forearm a week ago to the facility CNA and LPN. She stated that she did not remember what the CNA's name was or what the LPN's name was. The HHA also stated that the siderail on the left had been padded, however she had not seen any padding on the side rail on the right side since she had been caring for the resident. On 06/06/24 at 09:00 AM, the Director of Nursing (DON) provided the surveyor incident and accident reports and investigations for the last 6 months for Resident #117. There were no incident or accident investigation for the bruise of the left forearm, however there was an incident and accident investigation provided for the skin tear of the right arm. On 06/06/24 at 09:25 AM, the surveyor interviewed the CNA who stated that the resident's left siderail had been padded, however the right siderail had not been padded for a couple months. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/06/24 at 10:27 AM, the surveyor interviewed LPN #1 who stated that purpose of the CP was to assure that special needs of the resident was provided. He stated that the CP assured that all staff members knew what needs the resident had and to provide those needs. He stated that he usually reviewed the residents CP quarterly when the skilled nursing assessment was completed. LPN #1 explained that nurses were made aware when skilled nursing assessment was due for a resident because it would trigger on the daily EMR when it was scheduled. LPN #1 stated explained that he was aware that Resident #117s siderails should be padded to protect the resident's skin, however had no explanation as to why the residents right siderail was not padded. He stated that the skin assessments were completed when the resident's bath was scheduled. He stated that the skin assessment should include any abnormalities of the skin. On 06/06/24 at 10:37 AM, the surveyor interviewed the DON who stated skin assessments were scheduled during first shower day of the week and the nurse was responsible to assess the skin for any abnormalities such as bruises, pressure ulcers, skin tears etc. She stated that if the nurse identified a bruise or any other skin impairment then the nurse would be responsible to assess the area, document findings, complete an incident report incident of unknown origin, start an investigation, and get a statements from CNAs going back three shift. She stated that the nurse was also responsible to alert the practitioner and the resident's family. She also indicated that the nurses would be responsible to notify the DON. The DON explained the CP process to the surveyor and stated that CPs were developed to assure that resident needs and preferences were identified, to include mitigating risk that could potentially negatively impact the resident and to mitigate those risk by formulating interventions to prevent accidents or incidents. She stated that an example of a resident risk would include a resident that had an issue with flailing arms and had the potential of bruising or developing skin tears from this behavior and the facility would pad the residents side rails or provide skin protectant sleeves to prevent skin tears. On 06/06/24 at 11:41 AM, the surveyor interviewed LPN #2 who performed the skin assessment for Resident #117 on 06/04/24 at 08:01 PM. LPN #2 stated that skin assessments were done once a week with shower. The LPN explained that the nurse usually performed the skin assessment with the CNA present. The LPN stated that she asked the CNA that was assigned to the resident on the evening of 06/04/24 how the residents skin condition was, and the CNA told her that the resident had no skin issues. The LPN admitted that she did not actually assess and visualize the residents' skin and that she relied on the CNA to inform her of any skin abnormalities. She stated that she trusts the CNA and that the CNA was dependable to give an accurate description of the resident's skin condition. She stated that the CNA did not report to her that the resident had a large bruise on the left forearm. On 06/06/24 at 12:08 PM, the surveyor interviewed the DON who stated if the nurse performed a weekly skin assessment, the nurse should be visualizing the resident's skin and documenting the condition of the skin on the resident's progress notes. The DON examined Resident #117's left forearm in the presence of the surveyor and confirmed that the resident had a bruise on the left forearm that was in the healing stage. She stated that she would start the investigation. The DON stated that when the surveyor reported the bruise to the LPN, the LPN should have started the accident and incident investigation, even if the bruise was old or in a healing stage. The DON also indicated that that nurse who performed the resident's skin assessment on 06/04/24 at 08:01 PM, should not have depended on the CNA to give her a description of the resident's skin and should have assessed the resident's skin herself. The DON also accompanied the surveyor to Resident #117's room and confirmed that the both the residents siderails should have been padded as the CP interventions indicated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/07/24 at 09:01 AM, the surveyor team met with the DON and Licensed Nursing Home Administrator (LNHA) who stated that an investigation was started regarding Resident #117's left forearm bruise. She indicated that the siderail pad must have become dislodged and was on an armchair in the Resident #117's room. She indicated that a physician's order was obtained for the siderail pads so that the nurse would check to assure that they were in place in case it contributed to the bruising. She also stated that the facility-initiated training related to skin checks procedure and documentation of previous skin impairments and the incident reporting procedure. The facility policy titled Non-impaired Skin Integrity dated 09/15, indicated that the facility strived to identify all residents at risk for developing impaired skin integrity, the level and nature of the risk and initiate the appropriate plan of care. The policy also indicated that the licensed nurse was responsible for initiating the appropriate interventions according to the resident's level of risk and performing weekly visual skin integrity checks were to be completed by the licensed nurse or designee on the resident's bath/shower day. The facility policy titled, Incident Reporting/Injury Investigation Residents and Visitors dated 03/19, indicated that the facility strived to ensure that incidents involving a resident or visitor were recorded, patterns, or trends of occurrences were investigated, and measures were implemented to alleviate or decrease further occurrences. The policy indicated that the description of the resident's incident/injury, resident status, intervention, and any relevant observation shall be documented in the electronic progress notes. The policy also indicated that resident incidents shall be reported to the nursing supervisor and that an incident report had been completed in its entirety and that upon receipt of a report of incident/injury the charge nurse of supervisor shall immediately evaluate the resident, provide any needed intervention, and complete all areas of the Incident Investigation form. The facility policy titled, Person-Centered, Interdisciplinary Care Planning and Care Conference dated 10/2022 reflected that the facility ensured that the person-centered, interdisciplinary care plan team members follow-through with their responsibilities and identify problems/needs and strengths and follow-up on the approaches. NJAC 8:3.9-4.1(a)5 NJAC 8:3.9-13.4(c)2i, ii

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41260 Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 06/05/24 from 8:56 AM to 9:25 AM, the surveyor, accompanied by the Regional Culinary Director (RCD) observed the following in the kitchen: 1.) The RCD washed her hands at a designated hand washing sink for 12 seconds. 2.) The step can style trash can at the employee hand washing sink had small flying insects (identified by the RCD as fruit flies) flying inside and outside of the trash can when opened. When the surveyor stepped on the pedal to open the trash can, there was a white paper towel with an orange discoloration inside with small insects crawling on it. The RCD stated she would get someone to empty the trash can. 3.) In the refrigerator, identified as the Produce Refrigerator by the RCD, there was a half pan of carrots sealed with plastic wrap. The half pan of carrots was not labeled with a date the carrots were prepared nor a use-by date. The RCD removed the half pan of carrots from the refrigerator. On 06/06/24 from 11:50 AM to 12:10 PM, the surveyor, accompanied by the RCD and Culinary Director (CD), observed the following in the kitchen: 4.) Two (2) Line Cooks and one (1) Prep [NAME] were wearing beard guards that did not cover their mustache facial hair. The RCD instructed the kitchen staff to pull their beard guards over their mustaches. 5.) A multi-tiered shelving unit, identified by the RCD as the storage area for clean and dry dishware, contained a stack of full pans and a stack of third pans that were wet nested. The surveyor lifted the pans to reveal there was liquid between the pans. The RCD instructed kitchen staff to re-wash the pans. During an interview with the surveyor on 06/06/24 at 12:50 PM, the RCD stated the following: 1.) The process for hand washing included washing hands for 15-20 seconds to prevent cross contamination and food-borne illnesses. 2.) The trash cans at the hand washing sink were designated for hand washing purposes only and that the trash cans should be emptied and kept clean for infection control purposes. The RCD further stated that pest issues, such as fruit flies, should be reported to management as fruit flies can lay eggs and continue to spread if not eliminated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.) The sealed carrots should have been labeled with the date they were prepped and would be good for three (3) days since it was a prepared product. 4.) [NAME] guards, a type of hair restraint, should cover all facial hair, including mustaches, to prevent hair from entering food or food prep items, since hair is full of bacteria. 5.) Dishware, such as pans, should be air dried before storing nested and if pans are wet nested, they should be re-washed because, wet nesting promotes bacteria growth. Review of the facility's Hand Washing Procedure from the Culinary Services Manual, revised 12/07, included, Apply approximately one tablespoon of hand soap from proper dispenser to your hands. Join hands and work up a good lather for 20 seconds, in addition concentrate under nails, between fingers, and under wedding bands. Review of the facility's Trash policy from the Environmental Services Manual, revised 08/2011, included, All trash containers will be covered with a fitted metal or plastic cover, and In order to maintain sanitary conditions, trash containers should be lined with plastic liners. The policy did not address how to prevent and address pest issues related to trash cans in the kitchen. Review of the facility's Date Marking Ready-To-Eat Foods policy from the Culinary Services Manual, revised 02/17, included, All ready-to-eat foods will be labeled to include the following information: product name and date (month, day and year) the product was prepared or opened and the date the product should be used by. Review of the facility's Food Storage Chart, revised 10/14, included under 3 days for refrigerated storage was, ready-to-cook foods prepared on site. Review of the facility's Personal Appearance Standards from the Culinary Services Manual, revised 01/16, included, Men with facial hair, mustache and or/beard, must wear a beard guard while in the production kitchen, and, Hair restraints, such as hats, hair covering, or nets, and clothing that covers body hair shall be worn when in the production area where food is prepared or plated from a hot or cold work station. Review of the facility's Ware Washing policy from the Culinary Services Manual, undated, included, Allow cleaned items to air dry and cool completely before storing. NJAC 18:39-17.2(g)