STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315085	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Chestnut Hill LLC	360 Chestnut Street Passaic, NJ 07055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on interview, record review and policy review, the facility failed to protect the resident's right to be treated with respect and dignity when staff searched (1) one of 73 residents' (Resident #60) room without permission for linens and towels. This failure had the potential to cause resident to feel undignified. Findings Include: Review of the facility's policy titled, Quality of Life - Dignity, revised 10/2024, revealed, . Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, and individuality. Residents' private space and property shall be respected at all times. Staff will knock and request permission before entering residents' rooms. Staff will not handle or move a resident's personal belongings (including radios and televisions) without the resident's permission. Review of Resident #60's Admission Record, found in the electronic medical record (EMR) Profile tab, showed an admitted [DATE], with a diagnoses that included spinal stenosis, lumbosacral region, morbid (severe) obesity, nontraumatic subarachnoid hemorrhage, and major depressive disorder. Review of Resident #60's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/28/24, and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 12/02/24 at 1:10 PM, Resident #60 stated that I was in my room when the Director of Housekeeping came in. She started looking through my belongings, saying she was searching for linen and towels. I told her to leave and said she didn't have permission to be in my room nor search my room. She kept looking anyway. After finding nothing, she left. I reported this to the Administrator, who said they would handle it. The Director of Housekeeping hasn't entered my room since then. During an interview on 12/05/24, at 11:11 AM, the Director of Housekeeping stated she entered Resident #60's room because she believed Resident #60 was keeping extra facility items like linens and towels on large shelves in their room. It was the facility items, so I felt justified entering because these items belonged to the facility. Later, the Administrator trained me on the policy, explaining that I cannot enter and search residents' rooms without permission. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24 at 4:49 PM, the Administrator stated the Director of Housekeeping had been educated on needing permission to enter a resident's room and go through their personal items. A request was made for documentation of the education, but it was not provided by the end of the survey. NJAC 8:39-4.1(12)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 40902 Based on interview, record review and policy review, the facility failed to ensure a resident or resident's representative was informed of the risks and benefits associated with taking psychotropic medications for (2) two of (3)three (Resident #82 and #89) reviewed for unnecessary medication. Findings include: 1. Review of Resident #82's Face Sheet, located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility with diagnosis of Alzheimer's disease. Review of Resident #82's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/13/24, and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely cognitively impaired. Review of Resident #82's Care Plan dated 04/16/24, and located in the EMR under the Care Plan tab revealed, The resident uses psychotropic medication related to a diagnosis of dementia. Interventions indicated to administer Seroquel as ordered. Review of Resident #82's Physician Orders dated 10/08/24, and located in the EMR under the Orders tab revealed Seroquel (antipsychotic medication) 50 milligram (mg) 1 tablet at bedtime. Review of Resident #82's behavioral services Initial Consultation dated 09/25/24, and located in the EMR under the Miscellaneous tab revealed psychiatric medication was Seroquel 500mg at bedtime for Alzheimer's. Further review revealed benefits outweigh risks was checked but risk versus benefits explained was not. Review of Resident #82's EMR revealed no documented evidence of risk versus benefits for antipsychotic medication use. During an interview on 12/05/24 at 4:53 PM, the Director of Nursing (DON) stated after staff receive an order for psychotropic medications she expected that they would review the risk and benefits. She said that it should be documented and the form scanned into the EMR. 15189 2. Review of Resident #89's Face Sheet found in the EMR under the Profile tab revealed the resident was admitted to the facility with diagnoses of unspecified dementia, unspecified severity, with psychotic disturbance and dementia in other diseases, with other behavioral disturbance. Review of Resident #89's quarterly MDS with an ARD of 09/06/24, indicated a BIMS score of 99 indicating the resident was unable to complete the interview. The assessment indicated the resident was receiving antipsychotic's on a routine basis only. During an interview on 12/03/24 at 8:50 AM, Resident #89's resident representative stated that she had concerns with side effects of the medications that the resident was receiving. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #89's Physician Orders dated 12/03/24, and found in the EMR under the Orders Tab indicated Rexulti 0.5 mg. (an antipsychotic medication started on 08/16/24) one tablet by mouth one time a day and Seroquel 50 mg (antipsychotic medication started on 10/08/24) one tablet by mouth two times a day for dementia with behavioral disturbance. Further review revealed that Resident #89 was receiving Seroquel 50 mg one tablet two times a day for agitation dated 08/29/24. Review of Resident #89's Medication Administration Record (MAR) dated December 2024, found in the EMR under the Orders tab indicated that Rexulti and Seroquel were being given per physician's orders from 12/01/24 through 12/05/24. Review of Resident #89's progress notes located under the Prog Note Tab of the EMR revealed on 08/29/24, the nurse documented Attempted to explain [name of resident's responsible party] in person reason for new medication added by MD, Seroquel 50 mg. [Name of responsible party] stormed out, do whatever you want. Review of Resident #89's EMR revealed no documentation that Resident #89's resident representative had been informed of the risks and benefits of taking antipsychotic medications. Interview on 12/05/24 at 4:56 PM, the DON was unable to provide Resident #89's documentation that the resident representative had been provided with information regarding the risk and benefits of taking antipsychotic medication. Review of the facility's policy titled, Use of Psychotropic Medication revised 06/2024 included, Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. NJAC 8:39-4.1(2)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on interview, policy review and record review, the facility was unable to provide documentation that (1) one of (2) two residents (Resident #51) reviewed for personal funds received their quarterly statements. Findings include: Review of Resident #51's Admission Record, found in the electronic medical records (EMR) Profile tab showed an admitted [DATE]. Review of Resident #51's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/30/24, located under the MDS tab of the EMR revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 12/02/24 at 12:49 PM, Resident #51 stated that he/she has never received any financial statements documenting these funds. During an interview on 12/05/24 at 9:58 AM, the Business Officer Director stated that the facility maintains a system where residents receive quarterly financial statements every three months. For cognitively intact residents, these statements are delivered directly to them. Regarding Resident #51, when asked to provide Resident #51's signed quarterly statements, the Business Office staff was unable to produce any documentation that Resident #51 had received their quarterly statements. Review of the facility's policy titled, Personal Funds dated 02/23 revealed, . The resident has a right to manage his or her financial affairs . The individual financial record must be available to the resident through quarterly statements and upon request . NJAC 8:39-4.1(a) (7)(9)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on interview, record review, and review of facility policy, it was determined that the facility failed to ensure residents had the correct code status, which matched their physician's orders in the medical record, that identified their wishes in the event of a medical emergency. This deficient practice was identified for 3 of 31 residents reviewed for code status (Resident #4, R #36, and R #40). 1. Resident #40 had a Practitioner Orders for Life-Sustaining Treatment (POLST; a form that enables residents to indicate their preferences regarding life-sustaining treatment) dated [DATE], for a full-code status (all resuscitation procedures will be provided when a person stops breathing or their heart stops beating). A review of a physician's order (PO) dated [DATE], indicated the resident had a code status of do not resuscitate (DNR; do not perform cardiopulmonary resuscitation (CPR) if a person's heart stops or they cease breathing). Interview on [DATE], with Resident #40's guardian, Family Member (FM #2), revealed that the resident was always a full-code status; that during an emergency response, the resident wanted all resuscitation procedures implemented. Interview with staff on [DATE], revealed that during an emergency response, the resident was coded as a DNR so CPR would not be performed. 2. Resident #4 had an undated POLST that was scanned into the electronic medical record (EMR) on [DATE], for a code status of DNR and do not intubate (DNI; do not place a breathing tube into a person's airway). A review of the PO dated [DATE], indicated the resident had a full-code status. Interview on [DATE], with Resident #4's FM #1, revealed the resident had a DNR code status; that during an emergency response, the resident did not wish for CPR to be performed. 3. Resident #36 had a POLST dated [DATE], for a code status of DNR and DNI; that the resident during an emergency response did not wish to have CPR performed. A review of the PO dated [DATE], indicated that the resident had a full-code status. Interview with staff on [DATE], revealed that the resident had a full-code status; that during an emergency response, all resuscitation procedures would be implemented. The facility's failure to ensure the residents' code statuses were correct during an emergency response, posed the likelihood of serious harm or death for the residents by receiving an incorrect emergency response. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on [DATE], when the survey team identified the conflicting code statuses. The facility Administration was notified of the IJ on [DATE] at 10:45 PM. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 7:05 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on [DATE]. Findings Include: (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's Advance Directives policy dated revised ,d+[DATE], included .Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The interdisciplinary Team will review annually with the resident his or her advance directives to ensure such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS). The Director of Nursing Services or designee will notify the Attending Physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. The Attending Physician will not be required to write orders for which he or she has an ethical or conscientious objection . A review of the facility's Code Status policy dated 2024, included it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. Policy Explanation and Compliance Guidelines: l. The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and formulate an Advance Directive. 2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include but are not limited to: a. Full Code b. Do Not Resuscitate c. Do Not Intubate d. Do not Hospitalize 3. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code. 4. The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services. 5. The resident's code status will be reviewed quarterly and documented in the medical record . 1. A review of Resident #40's Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included; lobar pneumonia (form of pneumonia), muscle weakness, anemia, hyperlipidemia (high blood cholesterol), dementia, and hypertension (high blood pressure). A review of Resident #40's EMR under the Orders tab revealed a PO dated [DATE], for the code status of DNR. A further review of the EMR revealed a POLST dated [DATE], located under the [Miscellaneous] tab, which indicated the resident had a full-code status. A review of the individualized comprehensive care plan (ICCP), located under the Care Plan tab of the EMR, revealed Resident #40 had a full-code status dated [DATE]. During an interview on [DATE] at 11:59 AM, Resident #40's guardian, FM #2, revealed before Resident #40 was admitted to the facility, they (the guardian and R #40) had it put on paper that Resident #40 was to be resuscitated. FM #2 stated, This has not changed, and no one from the facility has discussed this with me. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 4:09 PM, with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Director of Clinical Services (DCS), the concern regarding Resident #40's code status was addressed. The surveyor reviewed the physician's orders with administration and the DON and the DCS confirmed Resident #40 had a DNR code status, and staff followed that order. The surveyor then reviewed with administration Resident #40's POLST and ICCP which reflected the resident was a full-code status. At that time, the DCS acknowledged the discrepancies and stated the facility needed to ensure the resident's code status was correct and consistent throughout the medical record. 42440 2. A review of Resident #4's Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses including; heart failure, sepsis (infection of blood stream), malignant neoplasm of prostate (prostate cancer), pressure ulcer to sacrum region, stage 3 (full-thickness skin loss to lower back), and depression. A review of the [Miscellaneous] tab of the EMR included an undated POLST which was scanned into the EMR on [DATE]. The form indicated the resident had a code stats of DNR and DNI, and it was signed by Resident #4's FM #1 and a physician. A review of Resident #4's ICCP located under the Care Plan tab of the EMR, included a focus revised [DATE], that Resident #4 had an advance directive as evidenced by POLST for DNR and DNI. A review of Resident #4's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated a severely impaired cognition. A review of Resident #4's Admission Record, located in the EMR under the Profile tab, revealed Resident #4 was discharged to the hospital on [DATE], and returned to the facility on [DATE]. A review of Resident #4's Orders tab of the EMR revealed all physician's orders were discontinued when Resident #4 was discharged to the hospital on [DATE]. There was no documented evidence that a PO for Resident #4's code status was written upon Resident #4's return to the facility on [DATE]. A review of a binder located at the nurse's station titled, A Wing Resident POLSTs included Resident #4's original undated and signed POLST, which had been scanned into the [Miscellaneous] tab of the EMR on [DATE]. During an interview on [DATE] at 11:40 AM, the Licensed Practical Nurse (LPN #1) stated if a resident stopped breathing and their heart stopped beating, they went under the miscellaneous tab in the EMR and looked for the POLST. LPN #1 continued that code status also showed up as an order and was listed under the Code Status tab of the EMR. LPN #1 stated that staff did not rely on the order; that they always verified with the POLST. When asked if there was anywhere else to find a resident's code status, LPN #1 stated the original POLST was located in binders on each of the three units. An observation on [DATE] at 1:44 PM, revealed a purple dot next to Resident #4's name outside of the resident's door. The purple dot indicated the resident a had DNR code status. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #4's Orders tab of the EMR revealed that on [DATE] at 3:02 PM, a PO for full code was entered. During an interview on [DATE] at 3:22 PM, FM #1 stated they were the medical Power of Attorney (POA) and made medical decisions for Resident #4. FM #1 stated Resident #4's code status was DNR. When asked if the facility had reviewed the code status with them recently, FM #1 stated Resident #4 had been on hospice services at one time, but FM #1 had taken Resident #4 off hospice services in [DATE] for treatment at the hospital. FM #1 stated Resident #4's code status had remained as DNR, and there was no further discussion about code status between FM #1 and the facility after the September hospitalization . 40902 3. A review of Resident #36's Admission Record face sheet reflected the resident was readmitted to the facility with diagnoses which included; muscle weakness, hemiplegia and hemiparesis following cerebral infarction (total or nearly complete paralysis on one side of the body following a stroke), difficulty in walking, and dementia. A review of the scanned POLST dated [DATE], located in the [Miscellaneous] tab of the EMR filed under Social Services revealed for code status, the resident was a DNR and DNI. A review of Resident #36's ICCP dated [DATE], and revised [DATE], included the resident had an advanced directive for DNR and DNI. Interventions included; do not perform CPR; follow facility protocol for identification of code status; follow living will/wishes; keep family informed of change in condition; and review code status quarterly and as needed (PRN). A review of Resident #36's most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 12 out of 15, which indicated a moderately impaired cognition. A review of Resident #36's Physician Orders dated [DATE] at 11:47 AM, located in the resident's EMR under the Orders tab did not include a PO for code status. Further review revealed a PO dated [DATE] at 3:28 PM, for a full-code status. Further review revealed a PO dated [DATE] at 4:40 PM, for a DNR status. A review of the code status binder, located at the B wing nurse's station, did not include a POLST with code status for Resident #36. During an interview on [DATE] at 11:40 AM, LPN #1 stated, if a resident stopped breathing and their heart stopped beating, they went under the miscellaneous tab in the EMR and looked for the POLST. LPN #1 continued that code status also showed up as an order and was listed under the Code Status tab of the EMR. LPN #1 stated that staff did not rely on the order; that they always verified with the POLST. When asked if there was anywhere else to find a resident's code status, LPN #1 stated the original POLSTs was located in binders on each of the three units. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:51 AM, the Assistant Director of Nursing (ADON) stated when a resident was found unresponsive, nursing checked the physician's orders for the code status and the POLST if the resident had one. The ADON stated that sometimes residents may not have a POLST form because they were not updated in the POLST binder along with the orders in the EMR. The ADON stated they were aware not all residents code status records were updated accurately, but she said that all residents should have a POLST that indicated full-code or DNR. During an interview on [DATE] at 11:53 AM, LPN #2 stated when a resident was found unresponsive, staff knew what their code status was by the colored dot placed on their name plate outside the resident's door that corresponded with the color-coded list staff wore on their name badge. At that time, LPN #2 was not wearing her badge and retrieved a small piece of paper that indicated a purple dot was for DNR. LPN #2 was unsure of anywhere else where a resident's code status was documented; she indicated residents with a green heart meant they were on precautions. During an interview on [DATE] at 2:43 PM, LPN #3 stated when a resident was found unresponsive, nursing staff checked in the EMR for the physician's order, and they looked in the POLST binder. LPN #3 stated the POLST form was also scanned into the resident's EMR under the Miscellaneous tab, and that all residents should have a signed POLST. LPN #3 stated if a resident did not have a POLST, they made the Social Worker aware so that one would be completed for them. LPN #3 stated if a resident's EMR did not have an order with code status and there was not a POLST, the resident was automatically a full-code. LPN #3 stated if there was a discrepancy between the PO and the POLST, they went by the POLST since that was signed by the resident and/or the responsible party. LPN #3 stated there was no other place to check for code status; that all residents with a DNR status had a purple dot on the resident's name plate located outside the resident's room. LPN #3 stated the Unit Clerk was responsible for putting the dots on the name tags. During an interview on [DATE] at 2:56 PM, LPN #4 said when a resident was found to be unresponsive, nursing staff checked the physician's order in the EMR but sometimes they looked in the POLST binder. LPN #4 stated they looked at both the POLST forms and the orders in the EMR because they were not always updated at the same time. LPN #4 stated sometimes a POLST form was completed but the nurse on duty may not have been made aware. LPN #4 stated if there was a conflict between the PO and POLST, she called the physician or her ADON. LPN #4 stated the unit clerks updated the POLST binder, but she was not sure when or how that was completed. LPN #4 stated she was not sure who completed the POLST form, but the floor nurse on duty at the time a resident was admitted put the orders in the EMR. LPN #4 stated she was not sure if the POLST binder was audited to ensure it reflected the same information as what was in the resident's EMR. During an interview on [DATE] at 3:17 PM, the Unit Clerk (UM #1) stated after a resident's admission, the Social Worker met with the resident and family and went over advanced directives and had the POLST form signed. UM #1 stated that after the POLST was signed, it was provided to a unit clerk who gave it to the physician to review and sign. UM #1 stated the unit clerk uploaded it into the EMR and placed a copy in the binder and let the nurse on duty know at that time. UM #1 stated if a resident had DNR orders, there was a purple dot on the resident's name plate outside their door, and if there was a change, the Social Worker was made aware, and they went through the same process as admission. UM #1 stated she was not sure if there were any audits completed to ensure all the residents' information in their EMR correctly reflected their code status. UM #1 stated she personally did a walk through of the building every morning and looked at all the doors but agreed she would not know 100% of all residents that had DNR orders. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on [DATE] at 4:09 PM, with the LNHA, DON, and DCS to discuss the code status process. The DON indicated that the Social Worker met with the family to discuss the code status, and once both the family and physician signed off on the code status, the information went to the nurse for entry into the chart. The DON stated that information was collectively reviewed during the quarterly care plan meetings, and if a POLST was absent in the binder, the resident was considered a full-code. During an observation and interview with LPN #3 on [DATE] at 5:12 PM, it was observed that Resident #36's name plate outside their door did not have a purple dot. LPN #3 stated Resident #36 was a full-code and not a DNR, and that was why they did not have a purple dot. This statement contradicted the resident's POLST, which indicated Resident #36 was a DNR and DNI. The acceptable Removal Plan (RP) on [DATE] at 7:05 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; facility's Code Status policy updated to include process for obtaining and reviewing code status; all nurses were educated on verification of code status upon admission, completion of the POLST, updating of code status physician's order and updating of ICCP with code status consistent with POLST and advanced directive, and facility's Code Status policy; all residents' POLST and advanced directives reviewed for accuracy and updated as needed; and residents with no POLST or advance directives code statuses were verified with the resident or responsible party. NJAC 8:,d+[DATE].1(a)(2) NJAC 9.6

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Chestnut Hill LLC	360 Chestnut Street Passaic, NJ 07055

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40902 Based on record review, interview, and policy review, the facility failed to report to the State Agency (SA) an allegation of neglect after a resident fell out of bed while staff was providing care and sustained a head injury for one of three residents (Resident #99) reviewed for abuse. Findings include: Review of Resident #99's Face Sheet, located in the electronic medical record (EMR) under the Profile tab revealed a diagnosis of dementia. Review of Resident #99's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/05/23, and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Further review revealed Resident #99 had a history of falls within the last month and within the last 2-6 months prior to admission. Review of Resident #99's Care Plan, dated 01/04/23, and located in the EMR under the Care Plan tab revealed no care plan specific to the number of staff required for bed mobility or incontinence care. Review of Resident #99's Nurse's Note dated 04/01/23 at 7:51 AM, located in the EMR under the Notes" tab and written by Licensed Practical Nurse (LPN #1) revealed, . responded to a call from Certified Nurse Aide (CNA #9) .found the resident lying on the floor. [CNA #9] indicated, I was changing [the resident] and turned [the resident] towards the right side of the bed, After I turned [Resident #99], he/she suddenly pushed [themselves] out of the right side of the bed and fell on the floor. Laceration to left eyebrow, blood coming out from resident nose, redness/swelling to left cheek . Review of Resident #99's Hospital discharge date d 04/04/23, located in the EMR under the Miscellaneous tab revealed, computed tomography (CT) of facial bones revealed supraorbital soft tissue swelling on the left and a probable mild fracture of the tip of the left nasal bone. Further review revealed a left black eye and laceration above left eyebrow. During an interview on 12/05/24 at 4:53 PM, the Director of Nursing (DON) stated this incident was not reported to the SA and that she expected an incident like this to be reported to the SA. Review of the facility's policy titled Abuse Policy dated 05/2024 revealed, .it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, .Neglect means failure of the facility, its employees, or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency (SA) .Immediately but no later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40902 Based on record review, interview, and policy review, the facility failed to thoroughly investigate an allegation of neglect after a resident fell out of bed while staff was providing care and sustained a head injury for one of three residents (Resident #99) reviewed for abuse. Findings include: Review of Resident #99's Face Sheet, located electronic medical record (EMR) under the Profile tab revealed a diagnosis of dementia. Review of Resident #99's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/05/23, and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Further review revealed Resident #99 had a falls history within the last month and within the last 2-6 months prior to admission. Review of Resident #99's Nurse's Note, dated 04/01/23 at 7:51 AM, located in the EMR under the 'Notes" tab and written by Licensed Practical Nurse (LPN) 1 revealed, . responded to a call from a Certified Nurse Aide(CNA #9) and found the resident lying on the floor. [CNA #9] stated, I was changing [the resident] and turned [the resident] towards the right side of the bed, After I turned [Resident #99] he/she suddenly pushed [themselves] out of the right side of the bed and fell on the floor. Laceration to left eyebrow, blood coming out from resident nose, redness/swelling to left cheek . Review of Resident #99's Hospital discharge date d 04/04/23, located in the EMR under the Miscellaneous tab revealed, computed tomography (CT) of facial bones revealed supraorbital soft tissue swelling on the left and a probable mild fracture of the tip of the left nasal bone. Further review revealed a left black eye and laceration above left eyebrow. During an interview on 12/05/24 at 4:53 PM, the Director of Nursing (DON) stated this incident was not investigated by the facility and an incident like this should have been investigated to identify what occurred to prevent it from happening again. Review of the facility's policy titled Abuse Policy dated 05/2024 revealed it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Neglect means failure of the facility, its employees, or service providers to provide goods or services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. An immediate investigation is warranted when suspicion of abuse, neglect . NJAC 8:39-9.4(f)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 40902 Based on record review and staff interview, the facility failed to ensure that a Preadmission Screening and Resident Review (PASRR) Level I assessment was completed accurately for one resident (Resident #2) out of a total sample of 31 residents reviewed for Level 1 PASRR screenings. This had the potential to prevent or delay additional services to a resident that may qualify for Level II services. Findings include: Review of Resident #2's Face Sheet, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was readmitted to the facility with diagnosis which included schizophrenia. Review of Resident #2's Care Plan, dated 06/04/22, and located in the resident's EMR under the Care Plan tab, revealed, The resident is at risk for adverse effects of psychotropic medications related to a diagnosis of schizophrenia. Review of Resident #2's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/04/22, and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated the resident was severely cognitively impaired. Review of Resident #2's Diagnosis list, dated 06/23/22, and located in the resident's EMR under the Diagnosis tab, revealed a diagnosis of schizophrenia. Review of Resident #2's behavioral services Initial Consultation dated 06/27/22, and located in the EMR under the Miscellaneous tab, revealed a diagnosis of schizophrenia. Further review revealed a history of psychiatric hospitalization s. Review of Resident #2's, NJ Department of Human Services Pre-Admission Screening and Resident Review (PASRR) Level I screen, dated 06/23/22, and located in the resident's EMR under the Miscellaneous tab, revealed no indication of mental illness identified or history of psychiatric hospitalization s. During an interview on 12/04/24 at 5:48 PM, the Social Services Director (SSD) stated after a resident was admitted , she would review their PASRR Level I and made sure they were completed accurately. She further stated she must have completely missed Resident #2's Level I screen and did not indicate a diagnosis or Schizophrenia or that Resident #2 had any past psychiatric hospitalization s when she reviewed Resident #2's PASRR. The SSD acknowledged that the information should have been reflected on the residents' Level I screen and that she did not complete it accurately. The SSD stated she has never received any official PASRR training. She stated she had just been winging it. During an interview on 12/05/24 at 4:53 PM, the Director of Nursing (DON) stated she was not familiar with the PASRR process or requirements, but she expected staff to ensure they were completed accurately. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility's policy titled, Coordination-Pre-Admission Screening and Resident Review (PASRR) program, updated 07/2024, revealed it is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident review, in accordance with State and federal regulations. NJAC 8:39-5.1(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on observation, interview, record review, and facility policy review, the facility failed to ensure care plans were updated for placement of a new suprapubic catheter, pressure ulcer treatment and prevention, change in eating ability, and smoking for four of 31 residents (Residents #4, R #13, R #61, and R #301) and failed to schedule and hold quarterly care plan meetings with residents and families for five residents (R #4, R #60, R #51, R #3, and R #50) out of 31 residents in the sample. As a result of this deficient practice, the residents had the potential for unmet care needs. Findings include: 1. Review of Resident #4's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an initial admitted [DATE], with a diagnoses of obstructive and reflux uropathy. Review of Resident #4's Care Plan, located in the Care Plan tab of the EMR and dated 11/28/23, revealed, . [Resident #4] has an indwelling catheter . Review of Resident #4's significant change Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/27/24, revealed a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating Resident #4 had severe cognitive impairment. Review of Resident #4's Prog (Progress) Note tab of the EMR revealed a General Note, dated 11/22/24 at 1:42 PM, which indicated that hospice called and reported that Resident #4's urinary catheter had been discontinued and a suprapubic catheter had been placed. Review of Resident #4's Care Plan, located in the Care Plan tab of the EMR, revealed no documented evidence that the care plan was updated to address the placement of the suprapubic catheter and discontinuation of the urinary catheter. During an interview on 12/05/24 at 4:12 PM, the MDS Coordinator (MDSC) acknowledged Resident #4 had a suprapubic catheter placed and no longer had a urinary catheter. The MDSC stated the suprapubic catheter should have been care planned. The MDSC stated the Assistant Director of Nursing (ADON) was responsible for updating the care plan. During an interview on 12/05/24 at 4:46 PM, the ADON reported she completed the nursing portion of the care plan and updated it with any changes. The ADON confirmed that the resident's care plan should have been updated to address the suprapubic catheter. During an interview on 12/05/24 at 5:20 PM, the Director of Nursing (DON) stated she expected Resident #4's suprapubic catheter to be on the care plan, especially since the resident had a recent hospital stay for a urinary tract infection. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan Notes, located in the Prog Note tab of the EMR, revealed three care plan reviews in 2024. They were dated 02/29/24, 05/28/24, and 08/13/24. All three meeting notes documented, Met with [Family Member] POA [power of attorney] via telephone to review care plan. During an interview on 12/03/24 at 3:22 PM, Family Member (FM #1) stated he was the medical Power of Attorney (POA) and made medical decisions for Resident #4. When asked if he attended care plan reviews, FM #1 stated he used to be invited to the meetings but not for about a year. FM #1 stated he wanted to attend a meeting with the interdisciplinary team since he had difficulty reaching management at times. 2. Review of Resident #13's Admission Record, located in the EMR under the Profile tab, revealed an initial admitted [DATE], with a diagnoses of periprosthetic fracture around internal prosthetic right hip. Review of Resident #13's annual MDS, located in the EMR under the MDS tab with an ARD of 07/15/24, revealed a BIMS score of 13 out of 15, indicating Resident #13 had intact cognition. Further review of the MDS indicated that Resident #13 was at risk for development of a pressure ulcer but had none. Review of Resident #13's Care Plan, in the EMR under the Care Plan tab, revealed a focus area initiated on admission on 07/08/24, and revised 07/26/24, for potential/actual impairment to skin integrity of the sacrum related to impaired mobility and incontinence. Interventions at that time included using a draw sheet or lifting device to move resident, initiated 07/08/24; keeping skin clean and dry, initiated 07/30/24; and assessing skin weekly on shower day and document findings on a weekly skin assessment, initiated 07/30/24. Review of a Wound Care note, dated 08/02/24, and located in the Misc tab of the EMR, revealed Resident #13 had developed a stage two pressure ulcer of the sacrum. A treatment of Medihoney was recommended. Review of the resident's care plan revealed the resident's care plan was updated to include the pressure ulcer and the treatment of Medihoney; however, there were no other interventions identified and implemented to help treat or prevent pressure ulcers. It was recorded that the pressure ulcer was resolved on 08/16/24. Review of a Wound Care note, dated 08/23/24, and located in the Misc (Miscellaneous) tab of the EMR, revealed Resident #13 had developed a new, stage three pressure ulcer on the sacrum. Review of Resident #13's Care Plan, in the EMR under the Care Plan tab, revealed interventions to encourage turning and repositioning in bed and to use a pillow to assist with positioning were initiated on 08/23/24, after the pressure ulcer re-developed. Review of Resident #13's Physician Orders, dated 10/17/24 and located under the Orders tab in the EMR revealed orders for skin prep wipes to the left and right heels topically every day and evening shift for skin condition, to offload heels when in bed every shift , and for an alternating air mattress. Review of Resident #13's Care Plan, located in the Care Plan tab of the EMR, revealed the care plan had been updated to include the skin prep to heels but not the alternating air mattress or floating of the heels. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's Resident Care Information document, located in a binder at the nurse's station, revealed a checkmark by No for wounds. Elevate heels on pillow when in bed, turn and reposition every two hours, and APM mattress were unchecked. During an interview on 12/05/24 at 10:23 AM, Certified Nurse Aide (CNA #6) stated she looked at the Kardex section of the residents' EMR or at the Resident Care Information document located in a binder at the nurse's station to know what care needs residents had. During an interview on 12/05/24 at 4:12 PM, the MDSC stated that the CNAs looked at the Kardex on the computer or at the Resident Care Information in the binders to know how to care for a resident. The MDSC stated measures to prevent pressure ulcers were expected to be on the Care Plan as were specialty mattresses. The MDSC stated the ADON was responsible for updating the care plan, and the ADON or nurses who knew the residents were responsible for updating the Resident Care Information. During an interview on 12/05/24 at 4:46 PM, the ADON reported she completed the nursing portion of the care plan and updated it with any changes, including pressure ulcer prevention. The ADON stated the nurses were responsible for updating the Resident Care Information, but sometimes she had to update it. During an interview on 12/05/24 at 5:20 PM, the DON stated nurses were expected to update the Resident Care Information when changes were noticed. The DON stated it was expected that new interventions to treat and prevent pressure ulcers were on the Care Plan so that future skin breakdown can be prevented. 3. Review of Resident #61's Admission Record, located in the EMR under the Profile tab, revealed the most recent admitted was 07/15/24. Resident #61 had diagnoses of myocardial infarction (heart attack) and vascular dementia. Review of Resident #61's Care Plan, in the EMR under the Care Plan tab and revised 08/08/24, revealed a goal, [Resident #61] will have stable weight 147 [pounds] +/- 5 [pounds] in the next 90 days. The care plan did not address what assistance Resident #61 required with eating. Review of Resident #61's quarterly MDS, located in the EMR under the MDS tab with an ARD of 09/24/24, revealed a BIMS score of three out of 15, indicating Resident #61 had severe cognitive deficit. Further review of the MDS indicated that the resident required substantial/maximal assistance (helper does more than half the effort) to eat. Review of Resident #61's most recent weight on 11/13/24, located in the Wts/Vitals tab of the EMR, revealed Resident #61 weighed 107 pounds. Review of Task: GG - Eating, dated 11/04/24 to 12/03/24, and located in the Task tab of the EMR, revealed Resident #61 was dependent on staff (required the helper to do all the effort) for all meals documented as eaten except for five. Review of Resident #61's Resident Care Information document, located in a binder at the nurse's station, revealed Resident #61 ate independently. On 12/05/24 at 8:30 AM, the surveyor observed CNA #6 feed Resident #61 in their room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 9:38 AM, the Registered Dietician (RD) reported that Resident #61 fed himself at the beginning of a meal but fatigued and needed assistance to finish. The RD stated she completed the care planning for nutrition. The RD stated she needed to edit the goal weight. She further stated it was from a past dietician and, while it may be the desired weight, it was unattainable at the time. During an interview on 12/05/24 at 10:23 AM, CNA #6 stated she looked at the Kardex in the residents' EMR or at the Resident Care Information located in a binder at the nurse's station to know what care needs residents had. CNA #6 reported that Resident #61 needed staff to feed him. During an interview on 12/05/24 at 4:12 PM, the MDSC stated CNAs looked at the Kardex on the computer or at the Resident Care Information in the binders to know how to care for a resident. The MDSC stated the ADON were responsible for updating the Care Plan, and the ADON or nurses who knew the residents were responsible for updating the Resident Care Information. During an interview on 12/05/24 at 4:46 PM, the ADON reported she completed the nursing portion of the Care Plan and updated it with any changes. The ADON stated the nurses were responsible for updating the Resident Care Information. The ADON stated assistance with eating went on the Resident Care Information and not on the Care Plan, since ADLs (activities of daily living) were not typically on the care plan. During an interview on 12/05/24 at 5:20 PM, the DON stated nurses were expected to update the Resident Care Information when changes were noticed. The DON stated the expectation was for feeding assistance to be on both the Resident Care Information sheets and the care plan so staff were aware of how to care for the residents. The DON stated the weight goal on the Care Plan was expected to be achievable. 4. Review of Resident #301's Admission Record, located in the EMR under the Profile tab, revealed an admitted [DATE]. Review of Resident #301's quarterly MDS, located in the EMR under the MDS tab with an ARD of 11/18/24, revealed a BIMS score of 11 out of 15, indicating Resident #301 had moderate cognitive impairment. Review of the undated document titled, Smoking Residents, provided by the facility on 12/02/24, revealed Resident #301 was the only resident who smoked. The form recorded that smoking times were 10:00 AM and 4:00 PM on the smoking patio. Review of Resident #301's Care Plan located in the EMR under the Care Plan tab and dated 08/20/24, revealed a focus area related to the resident being a smoker. Interventions included staff was to provide supervision while smoking. The Care Plan did not address resident specific abilities and how staff were to assist Resident # 301 smoking. Review of Resident #301's Resident Care Information document, located in a binder at the nurse's station, did not include that Resident #301 smoked. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 12/04/24 from 4:04 PM to 4:20 PM, Activities Assistant (AA #1) stated she took Resident #301 out to smoke daily at 4:00 PM when she worked, [Resident #301] was allowed to smoke one cigarette, and their cigarettes were kept at the nurse's station. AA#1 stated Resident #301 needed assistance to go to the smoking area since it was in the assisted living area of the facility. AA#1 was observed assisting Resident #301 to smoke. During an interview on 12/05/24 at 10:23 AM, CNA #6 stated she looked at the Kardex in the residents' EMR or at the Resident Care Information located in a binder at the nurse's station to know what care needs residents had. CNA #6 reported not knowing Resident #301 still smoked, where Resident #301 cigarettes were, or who currently assisted the resident to smoke. During an interview on 12/05/24 at 3:45 PM, the Social Services Director (SSD) stated nursing updated the care plans regarding smoking. During an interview on 12/05/24 at 4:12 PM, the MDSC stated CNAs looked at the Kardex on the computer or at the Resident Care Information in the binders to know how to care for a resident. The MDSC stated the SSD updated the smoking portion of the care plan. During an interview on 12/05/24 at 4:46 PM, the ADON stated the facility never put information on the care plan regarding smoking other than safety measures. The ADON stated staff were verbally informed of what to do for residents who smoked. During an interview on 12/05/24 at 5:20 PM, the DON stated she expected the Resident Care Information and the care plan to contain all the necessary information so staff would know how to assist Resident #301 with smoking. 5. Review of Resident #60's Admission Record, found in the electronic medical record (EMR) Profile tab, showed an admitted [DATE], with diagnoses that included spinal stenosis, lumbosacral region, morbid (severe) obesity due to excess calories, nontraumatic subarachnoid hemorrhage, unspecified, major depressive disorder, recurrent. Review of Resident #60's quarterly MDS, with an ARD of 08/28/24, and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 12/02/24, at 1:10 PM, Resident #60 was asked about if they participate in care plan meetings and/or interdisciplinary team (IDT) meetings. Resident #60 stated they had not attended or been invited to any such meeting. 6. Review of Resident #51's Admission Record, found in the electronic medical records (EMR), Profile tab, showed a facility admitted [DATE], with a diagnosis of Volvulus, acquired absence of other specified parts of the digestive tract, and type 2 diabetes mellitus with diabetic neuropathy, unspecified. Review of Resident #51's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/30/24, and located under the MDS tab of the EMR revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Chestnut Hill LLC	360 Chestnut Street Passaic, NJ 07055

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/02/24 at 12:49 PM, Resident #51 was asked about their participation in care plan meetings and/or interdisciplinary team (IDT) meetings. Resident #51 stated they had not attended or been invited to any such meeting. 7. Review of Resident #3's Admission Record, found in the Profile tab of the EMR, revealed Resident #3 was admitted to the facility on [DATE], with diagnoses which included osteopathy after poliomyelitis, right lower leg, opioid dependence, uncomplicated, syncope and collapse. Review of Resident #3's quarterly MDS, with an ARD of 07/11/24, and located under the MDS tab of the EMR, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. During an interview on 12/02/24 at 12:37 PM, Resident #3 was asked about their participation in care plan meetings and/or interdisciplinary team (IDT) meetings. Resident #3 stated she had not attended or been invited to any such meeting. During an interview on 12/03/24 at 4:38 PM, the SSD stated the facility had not maintained consistency in conducting care plan meetings. The SSD stated that the current process involved the Interdisciplinary Team (IDT) meeting separately to discuss resident needs, after which family members are contacted by phone to review the care plan information. During an interview on 12/05/24 at 3:50 PM, the MDSC stated the care plan calendar was provided to the SSD, the IDT met to review and update the care plan, and after the meeting, the SSD contacted the families to discuss the information. 8. Review of Resident #50's Admission Record, located under the Profile tab of the EMR revealed Resident #50 was admitted to the facility on [DATE]. Observation of Resident #50 on 12/02/24 at 2:00 PM, revealed that Resident #50 was being assisted to eat by a family member. During an interview with Resident #50's family member on 12/02/24 at 2:27 PM, she did not recall being invited to attend quarterly care plan meetings. Review of Resident #50's quarterly MDS, located under the MDS tab of the EMR, revealed that Resident #50's cognitive skills for daily decision making was severely impaired, and the resident was rarely/never understood. Review of Resident #50's Progress Notes, located under the Progress Notes tab of the EMR, revealed that a care plan meeting was held on 02/08/24. The resident's responsible party attended the care plan meeting. Other participants who attended the care plan meeting were the Director of Nursing (DON), the Dietary Manager (DM), the Social Services Director and an activities staff member. Further review of Resident #50's EMR revealed no documented evidence that a care plan meeting occurred after 02/08/24. During an interview on 12/03/24 at 7:08 PM, the SSD stated the receptionist set up a care plan meeting time, and the meetings could be done in person or via telephone. The SSD stated she was unable to determine if a care plan meeting had occurred for Resident #50 since 02/08/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 1:12 PM, the Director of Clinical Services stated that care plan meetings were scheduled quarterly, and staff from the interdisciplinary team should be present for care plan meetings. Review of the facility's Care Plan Revision policy, reviewed 2024, revealed, . The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change . Upon identification of a change in status, the nurse will notify the physician. The Interdisciplinary Team will discuss the resident condition and collaborate on intervention options . The care plan will be updated with the new or modified interventions. Care plans will be modified as needed by the MDS Coordinator or other designated staff member . Review of the facility's Care Planning policy, revised September 2023, revealed, . The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family . NJAC 8:39-11.2(e)(f)(h)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15189 Based on observation, interview, record review, and policy review, the facility failed to identify and/or implement interventions to prevent and/or treat pressure ulcers for three of six residents (Resident #92, R #101, and R #13) reviewed for pressure ulcers. Findings include: 1. Review of Resident #92's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed Resident #92 was admitted to the facility with diagnoses which included anoxic brain damage and functional quadriplegia. Review of Resident #92's Care Plan, located under the Care Plan tab of the EMR, revealed a care plan was initiated on 07/19/24, which identified the resident's risk for pressure ulcer development related to impaired mobility secondary to incontinence and diagnosis of diabetes mellitus. Care plan interventions included administering preventative treatment to groin, sacrum and buttocks area, avoiding positioning on bony prominences and monitor nutritional status via feeding tube. Review of Resident #92's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/26/24, and located under the MDS tab of the EMR, revealed that the Resident #92 had no pressure ulcer/injury, did not have a pressure reducing device for chair, and was not on a turning/repositioning program. Further review of the MDS indicated that the resident was dependent for mobility. Review of Resident #92's Weekly Skin Review, dated 07/30/24, located under the Assmnts (Assessments) tab of the EMR, revealed resident's Skin Intact. Review of Resident #92's Care Plan, located under the Care Plan tab of the EMR, revealed that care plan interventions added on 08/04/24, included to a use pillow to assist with repositioning. Review of Resident #92's Skin-Pressure Ulcer, assessment, dated 08/06/24, and located under the Assmnts tab of the EMR, revealed that the resident had a Stage II pressure ulcer of the buttock first observed on 08/06/24. The pressure ulcer was further described with light serous drainage and measured 1.5 cm x 1.5 cm x 0.1 cm. Further review of care plan revealed that the Interventions section was left blank. Review of Resident #92's Multi Wound Chart Details, completed by the wound consultant, dated 08/06/24, and located under the Misc (Miscellaneous) tab of the EMR, revealed that the resident had a Stage II right buttock pressure ulcer that measured 1.5 centimeters (cm) x 1.5 cm x 0.1 cm, with minimum serous exudate. Treatment recommendations included cleansing the wound with normal saline and applying zinc oxide cream every shift until discontinued, and turning and repositioning as per standard of care, avoiding positioning which places direct pressure to the wound site, limiting continuous time spent sitting to less than 2 hours per session on an appropriate pressure reducing surface, using a foam wheelchair cushion and encouraging patient to perform seat lifts or position shifts every 15 minutes while in chair (the resident would not have been able to perform seat lifts every 15 minutes while in chair due to diagnoses of anoxic brain damage and functional quadriplegia). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #92's Care Plan, located under the Care Plan tab of the EMR, revealed that care plan interventions added on 08/09/24 included providing incontinence care and turning and repositioning at least every two hours as tolerated. There was no documented evidence that recommendations for avoiding positioning which placed direct pressure to the wound site, limiting continuous time spent sitting to less than 2 hours per session on an appropriate pressure reducing surface, or providing a foam wheelchair cushion as recommended by the wound consultant on 08/06/24 were implemented on 08/06/24. Review of Resident #92's August 2024 Treatment Administration Record (TAR), located under the Orders tab of the EMR, revealed that the treatment to cleanse the resident's right buttock wound and apply zinc oxide was not initiated until 08/09/24. Further review revealed no documented evidence that nursing implemented the wound consultant's recommendations of 08/06/24, for turning and repositioning as per standard of care, avoiding positioning which places direct pressure to the wound site, limiting continuous time spent sitting to less than 2 hours per session on an appropriate pressure reducing surface, or a foam wheelchair cushion. Review of Resident #92's Skin-Pressure Ulcer, assessment dated [DATE], located under the Assmnts tab of the EMR, revealed that the resident's Stage II pressure ulcer of the buttock first observed on 08/06/24 was healed. Review of Resident #92's Care Plan, located under the Care Plan tab of the EMR, revealed care plan interventions were not added until 08/12/24, and at that time included assisting to shift weight in wheelchair every 15 minutes, assessing right buttock for worsening, keeping bed sheets flat and straight without wrinkles and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of Resident #92's Weekly Skin Review, dated 08/14/24, located under the Assmnts tab of the EMR, revealed, Skin Intact. Review of Resident #92's Multi Wound Chart Details, completed by the wound consultant, dated 08/16/24, and located under the Misc tab of the EMR, revealed the resident had an unstageable left buttock pressure ulcer that measured 8.3 cm x 7.8 cm x 0.3 cm, with minimum serous exudate and over 50% necrotic material. It was recorded the wound consultant performed sharp debridement of the wound. Treatment recommendations included cleansing the wound with Dakins 0.25% solution, pack with Dakin's 0.25% solution-dampened gauze, including undermining where present and border gauze daily until discontinued, and continue with all recommended offloading measures. Review of Resident #92's Skin-Pressure Ulcer, assessment dated [DATE], and located under the Assmnts tab of the EMR, revealed that resident had an unstageable pressure ulcer of the buttock first observed on 08/06/24. The pressure ulcer was further described with light serous drainage with 25-49% granulation, 25-49% eschar (gray/black/brown), 25-49% slough (moist yellow/grey) and measured 8.3 cm x 7.8 cm x 0.3 cm. The care plan Interventions section was left blank. Observation of Resident #92 on 12/02/24 at 4:47 PM, revealed the resident lying in bed. The resident was unresponsive to verbal stimuli when spoken to and dependent on staff for activities of daily living including the administration of nutrition and hydration delivered via tube feeding. The resident was noted with contractures of bilateral hands, and gauze was placed in each hand. The resident was noted with an indwelling urinary catheter and was receiving care by the nurse during observation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After an interview with the DON on 12/05/24, related to Resident #92's pressure ulcer, the DON provided the surveyor with the certified nursing assistant task document dated July 2024 and August 2024. There was no documented evidence that Resident #92 was turned and repositioned every two hours or that the resident's time sitting was limited to two hours per session. 2. Review of Resident #101's Admission Record, located under the Profile tab of the EMR revealed the resident was admitted to the facility on [DATE]. Review of the Braden Assessment, dated 7/14/23, and located under the Assmnts tab of the EMR, revealed a score of 15 with a category of low risk. Further review revealed occasionally moist, chairfast, slightly limited mobility, nutrition probably inadequate, and friction and shear as potential problems. Review of the Baseline Care Plan, dated 07/14/23, located under the Misc tab of the EMR, revealed the resident required one person assist for bed mobility and transfer, utilized a wheelchair for mobility, was occasionally incontinent of bowel and bladder, and had a history of skin integrity issues. Review of the 7/14/23, Nursing Comprehensive Assessment, dated 07/14/23 located under the Assmnts tab of the EMR, revealed there was no presence of pressure ulcers. Review of the Nutritional Assessment, dated 07/17/24, located under the Assmnts tab of the EMR, revealed that the resident had a sacral DTI (deep tissue injury). Review of the admission MDS, with an ARD of 07/18/23, revealed the resident did not have a pressure ulcer and had a pressure reducing device for chair and bed and turning and repositioning program. Review of the Weekly Skin Review, dated 07/19/23, and located under the Assmnts tab of the EMR, revealed the resident had a pressure wound to the sacrum. Review of the Skin-Other Wound Type, dated 07/21/23, and located under the Assmnts tab of the EMR, revealed that the resident had a DTI of sacrum that was first observed on 7/14/23, was present on admission, and wound status was improved. Further medical record review revealed there was no comprehensive assessment of the wound until 07/21/23. Review of the Multi Wound Chart Details, dated 07/21/23, and completed by wound consultant, revealed that Resident #101 had a deep tissue injury of the sacrum that measured 6 cm x 4 cm x - depth with no exudate. During an interview on 12/4/24 at 11:04 AM, the resident's representative, stated that she had informed the facility that the resident had a sacral wound that had developed within the first week of admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview of the Director of Clinical Services on 12/05/24 at 1:12 PM, revealed that when residents were identified with a skin issue, the physician and resident representative were notified, and a treatment order was obtained, and a wound consultation was obtained if appropriate. The DCS stated it was expected that nursing document assessment of residents' skin issues including measurements of pressure ulcers. The DCS stated the nurse that goes on wound rounds with the wound consultant was responsible for carrying out recommendations for treatments/interventions made by the wound consultant. 42440 3. Review of Resident #13's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an initial admitted [DATE], with diagnoses which included periprosthetic fracture around internal prosthetic right hip. Review of Resident #13's annual Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ARD) of 07/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating Resident #13 had intact cognition. Further review of the MDS indicated that Resident #13 was at risk for development of a pressure ulcer but had none. Review of Resident #13's Care Plan, in the EMR under the Care Plan tab and revised 07/30/24, revealed a focus area related to the potential/actual impairment to skin integrity of the sacrum related to impaired mobility and incontinence. Interventions included using a draw sheet or lifting device to move resident, keep skin clean and dry, and assess skin weekly on shower day and document findings on a weekly skin assessment. Review of a Wound Care note, dated 08/02/24, and located in the Misc tab of the EMR, revealed Resident #13 had developed a 3 cm x 2.6 cm x 0.1 cm Stage II pressure ulcer to the sacrum. Review of a Wound Care note, dated 08/16/24, and located in the Misc tab of the EMR, revealed Resident #13's sacral pressure ulcer had resolved. Review of Resident #13's Care Plan in the EMR under the Care Plan tab revealed a focus area revised on 08/16/24, that Resident #13's sacral stage two pressure area had resolved. There were no new interventions identified to aid in the redevelopment of the pressure ulcer. Review of a General Note, located in the Prog Note tab of the EMR, revealed an entry on 08/21/24 at 5:55 PM, indicating CNA [Certified Nurse Aide] reported reopening wound in the sacrum. Upon assessment, open wound above the sacrum 1x1 cm . MD aware of finding, order zinc to the area and wound care consult. Review of Resident #13's Care Plan in the EMR under the Care Plan tab revealed interventions to encourage turning and repositioning in bed and to use a pillow to assist with positioning were initiated on 08/21/24, after the pressure ulcer re-opened. Review of Resident #13's TAR, dated 08/21/24 through 08/23/24, and located under the Orders tab of the EMR, revealed no documented evidence of any treatment was completed to the resident's sacral pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's Orders tab in the EMR, revealed orders, dated 10/17/24, for skin prep wipes to left and right heels topically every day and evening shift for skin condition, to offload heels when in bed every shift was and an alternating air mattress. During an observation on 12/02/24 at 4:30 PM, Resident #13 was lying in bed with their heels positioned directly on the bed. During an observation on 12/04/24 at 1:17 PM, Licensed Practical Nurse (LPN #9) performed a treatment to the resident's sacral pressure ulcer. Before the treatment, Resident #13's heels were on the bed and were not floated. After the treatment, Resident #13 was positioned so that their right heel was floated and the left remained on the bed. During an observation on 12/05/24 at 8:55 AM, Resident #13 sat in bed with the head of the bed raised. Resident #13 heels rested directly on the bed. During an observation on 12/05/24 at 2:28 PM, LPN #1 looked at Resident #13's heels when asked about the orders for floating and skin prep. Resident #13 was seated in her wheelchair with socks and slipper in place. Upon removal of the footwear, Resident #13's heels were both noted to have blanchable redness, as stated by LPN #1. During an interview on 12/05/24 at 5:20 PM, the DON stated she expected interventions to be identified and implemented to treat breakdown, prevent further breakdown, and help prevent recurrence of a wound once it resolved. NJAC 8:39-27.1(e)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review and staff interview, the facility failed to ensure improper incontinent care was provided to dependent residents for 2 residents (Resident #12 and Resident #87) out of a sample of 31 residents. This had the potential to effect all residents who require staff assistance with incontinent care. Findings Include: 1. Review of Resident #12's Face Sheet, located in electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE], with diagnosis of dementia. Review of Resident #12's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/24, and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely cognitively impaired. Review of Resident #12's Care Plan dated 03/08/24, and located in the EMR under the Care Plan tab revealed, The resident is at risk for urinary tract infection (UTI) related to urinary incontinence and use of diuretics. Interventions in place were to clean peri-area with each incontinence episode, monitor for signs and symptoms of UTI, encourage fluids, report any possible causes of incontinence. During an observation on 12/04/24 at 12:24 PM, of Certified Nurse Aide (CNA #4) who took Resident #12 into the shower room across the hall from the resident's room. CNA #4 had Resident #12 stand while she placed a shower chair behind the resident and pulled down/off Resident #12's incontinent brief, which was saturated with urine. CNA #4 had Resident #12 sit on the shower chair and moved the shower chair over the toilet. Resident #12 verbalized she was done using the toilet, CNA #4 wiped the buttock/rectal area with moistened wipe once, by reaching her hand under the shower chair and reaching through the hole. CNA #4 did not wipe the front above the vaginal area or the folds between the legs, CNA #4 placed Resident #12's clean incontinent brief. During an interview on 12/04/24 at 1:43 PM, CNA #4 stated she was unable to wipe Resident #12 thoroughly in the front or perineal area since she was unable to reach under the seat well enough to wipe that area. She stated it is difficult to provide Resident #12 thorough incontinence care since the resident is unable to stand well enough to allow staff to wipe her appropriately. During an interview on 12/05/24 at 1:22 PM, the Infection Preventionist (IP) stated that wiping the resident once through the hole of the shower chair would be appropriate to thoroughly clean the perineal area or the front area under the stomach where a soiled incontinence brief touched a resident's skin. She said the number one reason to ensure proper incontinent care is the risk of UTI. During an interview on 12/05/24 at 4:53 PM, the Director of Nursing (DON) stated she expected staff to clean a resident thoroughly after providing incontinent care due to possible skin breakdown, and the risk for infections, like a UTI. 42440 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #87's Admission Record, located in the EMR under the Profile tab, revealed an initial admitted [DATE]. Review of Resident #87's annual MDS located in the EMR under the MDS tab with an ARD of 09/11/24, revealed a BIMS score of 15 out of 15, indicating Resident #87 was cognitively intact. It was recorded Resident #87 was always incontinent of urine and frequently had bowel incontinence. Review of Resident #87's Care Plan, in the EMR under the Care Plan tab and dated 12/11/23, revealed a focus of [Resident #87] is at risk for UTI [urinary tract infection] related to urinary incontinence. Intervention included to clean peri-area with each incontinence episode, and to wash, rinse, and dry the perineum. During an interview on 12/02/24 at 4:37 PM, Resident #87 stated that their skin breaks down easily when he/she does not receive frequent toileting or incontinent care. During an observation on 12/04/24 at 12:50 PM, CNA #4 assisted Resident #87 with toileting and incontinence care. CNA #4 sat Resident #87 on a shower chair and positioned the shower chair over the toilet. CNA #4 then removed Resident #87's visibly wet incontinent brief and confirmed that Resident #87's brief contained urine. CNA #4 allowed Resident #87 to use the toilet and then gloved and used disposable paper wipes, moistened at the sink, to provide incontinent care. CNA #4 reached under the shower chair and cleaned Resident #87's skin that was reachable through the hole in the shower chair. CNA #4 patted the skin with a hand towel to dry it through the hole in the shower chair. CNA #4 then had Resident #87 stand, while CNA #4 stood behind the resident and reached through Resident #87's legs with a wipe to clean front to back once. CNA #4 wiped the buttocks area again but did not clean the front of Resident #87. During an interview on 12/04/24 at 1:43 PM, CNA #4 reported she provided incontinent care and toileting for Resident #12 and Resident #87 in the morning and after lunch. CNA #4 reported she cleaned the perineal area when a resident was incontinent. CNA #4 stated the perineal area she could not reach as Resident #12 and Resident #87 sat on the shower chair, she did when they stood. CNA #4 verified that Resident #12 had not stood to be cleaned and said she had cleaned all the perineum through the hole in the shower chair. During an interview on 12/04/24 at 2:18 PM, Licensed Practical Nurse (LPN #9) stated residents should be checked for incontinence every two hours. LPN #9 stated when a resident was incontinent, nursing staff were to clean the perineal area in front and the backside. During an interview on 12/05/24 at 2:43 PM, CNA #11 stated for incontinent care, residents were wiped from one side of their lower abdomen to the other, then they are wiped down each side of their groin area and then down the middle/labia. Following that, the backside is cleaned. During an interview on 12/05/24 at 1:29 PM, the IP stated she expected staff to wash residents from the cleanest area to the dirtiest when performing incontinent care. The IP pointed to the lower abdomen, groin, and upper thighs of a resident's front side to clean before cleaning the backside. During an interview on 12/05/24 at 4:08 PM, the IP stated proper incontinence care was important for many reasons. The IP stated it was important to prevent infections and skin breakdown. (continued on next page)

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	315085	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Chestnut Hill LLC	360 Chestnut Street Passaic, NJ 07055

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/05/24 at 5:15 PM, the DON stated skin breakdown and risk for infection, specifically urinary tract infections, were a risk of improper incontinence care. Review of the facility's policy titled, Incontinence Care dated 01/2024 revealed will receive appropriate treatment and services. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident receiving oxygen therapy had orders in place for one of one resident (Resident #4) reviewed for oxygen. Findings include: Review of Resident #4's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an initial admitted [DATE]. Review of Resident #4's Care Plan, dated 08/02/24, and located in the Care Plan tab of the EMR, revealed, [Resident #4] has oxygen therapy r/t [related to] ineffective gas exchange. Interventions included oxygen therapy at two liters per minute (LPM) via nasal cannula. Review of Resident #4's Orders tab of the EMR revealed an order dated 09/22/24, for continuous oxygen at two liters per minute (LPM) via nasal cannula and for staff to check the resident's oxygen saturation levels. Review of Resident #4's significant change Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ARD) of 09/27/24, revealed a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating Resident #4 had severe cognitive impairment. Review of Resident #4's Admission Record, located in the EMR under the Profile tab, revealed the resident was transferred to the hospital on 11/25/24, and returned to the facility on [DATE]. Review of Resident #4's Orders tab of the EMR revealed all orders were discontinued when Resident #4 was discharged to the hospital on 11/25/24. No order for oxygen therapy was written upon Resident #4's return to the facility on [DATE]. During an observation on 12/02/24 at 11:45 AM, Resident #4 was lying in his bed with a nasal cannula in his nares. Resident #4's oxygen concentrator was running at three liters per minute. A portable oxygen tank with oxygen tubing in a bag hung from the back of Resident #4's wheelchair. During an observation on 12/02/24 at 3:00 PM, Resident #4 was lying in bed with oxygen running at three liters per minute via his nasal cannula. During an interview on 12/05/24 at 10:23 AM, Certified Nurse Aide (CNA #6) stated Resident #4 used oxygen continuously, if he/she left it in his/her nose. During an interview on 12/05/24 at 1:53 PM, Licensed Practical Nurse (LPN #1) reported not seeing an oxygen order that morning for Resident #4, so LPN #1 placed Resident #4's oxygen tubing back in his bag. LPN #1 stated Resident #4 received oxygen PRN (as needed). When asked if there should be orders for PRN oxygen, LPN #1 stated there should be an order for PRN oxygen for a resident who had oxygen in their room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/24 at 5:15 PM, the Director of Nursing (DON) reported she expected an order for oxygen if routine or PRN to ensure the correct administration. Review of the facility's Oxygen Administration policy, updated 10/2024, revealed, . Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: The date and time that the procedure was performed . the rate of oxygen flow, route, and rational, the frequency and duration of the treatment, the reason for p.r.n. [PRN] administration, all assessment data obtained before, during, and after the procedure, how the resident tolerated the procedure . NJAC 8:39-27.1

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, interview, and record review, the facility failed to ensure residents received alternative measures prior to installation of side rails, and that risk for entrapment was assessed for two residents reviewed for side rails (Resident #54 and R #36) of 31 sampled residents. The lack of alternate side rail measures and assessment for entrapment could lead to potential restraint or side rail entrapment. Findings include: Review of Resident #36's Face Sheet, located in the electronic medical record (EMR) under the Profile tab revealed the resident was readmitted to the facility on [DATE], with diagnoses which included muscle weakness, hemiplegia and hemiparesis following cerebral infarction, difficulty in walking, and dementia. Review of Resident #36's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/24, and located in the resident's EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Review of Resident #36's Care Plan, dated 10/26/21, and located in the resident's EMR under the Care Plan tab revealed, The resident was at risk for further decline in ADLs [Activities of Daily Living] related to a diagnosis of anemia. Interventions in place were 1/4 side rails as ordered. Review of Resident #36's Nursing Comprehensive assessment dated [DATE], and located in the EMR under the Assessments tab revealed risk for entrapment had not been completed and that no alternates were attempted prior to the placement of the siderails. 2. Review of Resident #54's Face Sheet, located in EMR under the Profile tab revealed the resident was readmitted to the facility on [DATE], with diagnosis of Parkinson's disease. Review of 54's quarterly MDS with an ARD of 10/30/24, and located in the EMR under the MDS tab revealed a BIMS score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Review of Resident #54's Care Plan, dated 11/14/23, and located in the EMR under the Care Plan tab revealed, The resident was at risk for further decline in ADLs related to diagnosis. Interventions in place were 1/4 side rails as ordered. Review of Resident #54's Nursing Comprehensive assessment dated [DATE], and located in the resident's EMR under the Assessments tab, revealed risk for entrapment had not been completed and that no appropriate alternates were attempted. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 8:01 PM, the Maintenance Director (MD) said he checks bedrails to ensure there was not a gap between the mattress and bedrail of more than 5-6 inches space between the mattress and siderail. He stated he got the 5-6 inches from looking online and that he uses a tape measurer. He said he is just measuring the distance between the side rail and the mattress, but he does not check for risk of entrapment. He said he does not have a device to check for the risk of entrapment. During an interview on 12/05/24 at 10:20 AM, Licensed Practical Nurse (LPN #1) said the nursing staff complete an initial assessment for bedrail use but they are not completed quarterly after that. He stated they have the resident or representative sign for consent for side rails but are not assessing appropriate alternatives prior to using them. During an interview on 12/05/24 at 10:39 AM, LPN #6 stated they get a physician's order for bed rails, and they complete a nursing assessment. She said they assess if the bedrails are safe by just doing a visual assessment. She said they look at the bedrails and see if anything looks unsafe. They do not explore using alternates prior to use. She said they use the bedrails for most residents as a safety measure since they are a falls risk. During an interview on 12/05/24 at 4:53 PM, the Director of Nursing (DON) stated nursing staff complete an initial assessment for bedrail use but they are not exploring alternatives. The DON stated that she thought they were completing them quarterly but she's not sure and she thought maintenance was checking for entrapment and making sure the bed rails were not loose. The DON was unaware that maintenance was measuring for a 5-6-inch space between the mattress and the bed and she did not know that it could not be more than 4 inches. Review of the facility's policy titled Bed Rail Policy dated 2024 revealed, it is the policy of the facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. NJAC 8:39-27.1(a)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411 Based on interviews and review of pertinent facility documents, it was determined that the facility failed to ensure the Licensed Nursing Home Administrator (LNHA) ensured staff implemented the facility's code status policy for residents during a medical emergency to ensure residents' wishes regarding life-sustaining treatments were honored. This deficient practice was identified for 3 of 31 residents reviewed for code status (Resident #4, R #36. and R #40). Refer F 578 1. Resident #40 had a Practitioner Orders for Life-Sustaining Treatment (POLST; a form that enables residents to indicate their preferences regarding life-sustaining treatment) dated [DATE], for a full-code status (all resuscitation procedures will be provided when a person stops breathing or their heart stops beating). A review of a physician's order (PO) dated [DATE], indicated the resident had a code status of do not resuscitate (DNR; do not perform cardiopulmonary resuscitation (CPR) if a person's heart stops or they cease breathing). Interview on [DATE], with Resident #40's guardian, Family Member (FM #2), revealed that the resident was always a full-code status; that during an emergency response, the resident wanted all resuscitation procedures implemented. Interview with staff on [DATE], revealed that during an emergency response, the resident was coded as a DNR so CPR would not be performed. 2. Resident #4 had an undated POLST that was scanned into the electronic medical record (EMR) on [DATE], for a code status of DNR and do not intubate (DNI; do not place a breathing tube into a person's airway). A review of the PO dated [DATE], indicated the resident had a full-code status. Interview on [DATE], with Resident #4's FM #1, revealed the resident had a DNR code status; that during an emergency response, the resident did not wish for CPR to be performed. 3. Resident #36 had a POLST dated [DATE], for a code status of DNR and DNI; that the resident during an emergency response did not wish to have CPR performed. A review of the PO dated [DATE], indicated that the resident had a full-code status. Interview with staff on [DATE], revealed that the resident had a full-code status; that during an emergency response, all resuscitation procedures would be implemented. This resulted in an Immediate Jeopardy (IJ) situation. The facility's failure to ensure the LNHA and staff implemented the code status policy to ensure residents' code statuses were correct during an emergency response posed a likelihood of serious harm or death for residents by receiving an incorrect emergency response. This resulted in an IJ situation. The IJ began on [DATE], when the LNHA identified it was the nursing staff's responsibility to ensure staff were properly trained on policy, procedure, and protocol. The facility was notified of the IJ on [DATE] at 6:05 PM. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 2:28 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings include: A review of the facility's Administrator Job Description dated revised ,d+[DATE], included plans, develops, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations; plans, develops, organizes, implements, evaluates and directs the facility's programs and activities in accordance with guidelines issued by the governing body; identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. establishes ongoing system to monitor these key indicators such as Quality Assurance and Performance Improvement process throughout the facility . A review of the facility's Code Status policy dated 2024, included it is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. Policy Explanation and Compliance Guidelines: l. The facility will follow facility policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive. 2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include. but are not limited to: a. Full Code b. Do Not Resuscitate c. Do Not Intubate d. Do not Hospitalize 3. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code. 4. The presence of an Advance Directive or any physician directives related to the absence or presence of an Advance Directive shall be communicated to Social Services. 5. The resident's code status will be reviewed quarterly and documented in the medical record . The policy did not include where nursing staff verified the resident's code status information; how to identify potential discrepancies in the medical records; or who was responsible for ensuring accuracy. 1. A review of Resident #40's EMR revealed a PO dated [DATE], for a code status of DNR. A further review of the EMR revealed a POLST dated [DATE], which indicated the resident had a full-code status. During an interview on [DATE] at 11:59 AM, with Resident #40's guardian, FM #2, revealed before Resident #40 was admitted into the facility, it was documented on paper that Resident #40 was to be resuscitated. FM #2 verified that Resident #40's wishes had not changed, and no one from the facility had discussed a change in code status with them. 2. A review of Resident #4's orders tab of EMR revealed all orders were discontinued when Resident #4 was discharged to the hospital on [DATE]. There was no PO for code status for Resident #4 upon their re-admission to the facility on [DATE], until [DATE] at 3:02 PM. On [DATE] at 3:02 PM, a PO for a full-code status was entered. A review of Resident #4's undated and signed POLST that was scanned into the EMR on [DATE], revealed that a physician signed the request by FM #1 for a DNR status. During an interview with FM #1 on [DATE] at 4:09 PM, FM #1 stated that Resident #4 had a code status of DNR. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. A review of Resident #36's Orders tab of the EMR revealed there was no PO for code status. A review of the POLST binder located at the nurse's station did not include a POLST for Resident #36. A review of the scanned POLST in the EMR dated [DATE], revealed Resident #36 had a DNR code status. During an interview on [DATE] at 10:54 AM, the LNHA acknowledged he was unaware that the residents' physician's orders for code status did not match their POLST. The LNHA stated that care plan meetings were held every quarter, and the resident's POLST and code status were discussed with the resident, family members, and the Interdisciplinary (IDT) team. The LNHA stated it was the responsibility of the nursing staff to ensure staff were properly trained on the facility's policy, procedure, and protocol. The LNHA confirmed he was unaware that staff were having issues implementing the code status policy and procedure. During an interview on [DATE] at 11:42 AM, the Medical Director stated he was not aware of the discrepancies with the residents' PO for code status and their POLST. The Medical Director stated he was unsure the facility's policy and procedure for code status because it was a nursing issue. When asked if a resident was found unresponsive what was the protocol for staff to determine code status and to respond appropriately, the Medical Director stated he did not know what the nursing staff did; probably go look in the computer or the POLST book. During an interview on [DATE] at 4:09 PM, the Director of Nursing (DON) stated she was unaware that staff were not fully aware of the protocol to follow for the residents' code status. The DON acknowledged she was unaware that the residents' PO for code status did not match their POLST. The acceptable Removal Plan (RP) on [DATE] at 2:28 PM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including; facility's Code Status policy was updated; the LNHA was educated on reviewing, developing, and implementing clear policies to staff regarding code status; Resident #4, Resident #36, and Resident #40's code status was updated; all residents' charts were reviewed to ensure the correct code status; and all nurses were educated on verifying code status upon admission, completion of POLST, updating of an order and care plan with code status. NJAC 8:,d+[DATE].1

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 22411 Based on record review, interviews, and policy review, the facility failed to maintain documentation of the facility's ongoing Quality Assessment and Performance Improvement (QAPI) program. This failure had the potential to negatively affect 103 of 103 residents who resided at the facility. Findings Include: Review of the facility's policy titled, QAPI Plan Quality Assessment and Performance Improvement, updated 05/24 indicated, . Complete Care's mission is to continue its long history of providing the highest quality person-centered post-acute short-term subacute rehabilitation and long-term care residency in an environment that couples warmth of care with clinical The administrator, or designee, is responsible for assuring that all QAPI activities and required documentation is completed and/or up to date. During an interview on 12/05/24 at 8:47 PM, with the Administrator, the [NAME] President of Quality and Processing and the Director of Clinical Services, regarding items being reviewed and implemented in the facility's QAPI meeting, it was reported weights, wound reports, and maintenance concerns had been reviewed, along with laundry issues. When asked to provide the QAPI meeting minutes for the last year, they indicated that they have the agenda sheets but no documentation of the minutes. The minutes were not provided prior to the survey team exiting the building. NJAC 8:39-33.1 NJAC 8:39-33.2