STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315091	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48964 Complaint # NJ00167683 Based on observation and interview, it was determined that the facility failed to maintain the residents' environment and living areas in a sanitary and homelike manner. This deficient practice was identified for 1 of 5 nursing units observed for the facility environment task. This deficient practice was evidenced by the following: On 7/22/24 at 10:30 AM, the surveyor observed dark dirty appearing areas in hallway on the 400 hallway and doorways. On 7/23/24 at 11:30 AM, the surveyor observed dark dirty appearing areas in hallway on the 400 hallway and doorways. On 7/24/24 at 9:49 AM, the surveyor observed dark dirty appearing areas in hallway on the 400 hallway and doorways. On 7/22/24 at 11:29 AM, the surveyor interviewed the porter who stated the floors are done daily. He also stated the rotunda was done already and that he has not done 400 wing yet. He further stated that he's usually the only porter and a floor tech works the weekends only. On 7/24/24 at 1:04 PM, the surveyor interviewed the Director of Housekeeping who stated that the procedure for cleaning the floors included both a wet mop machine and a mop /bucket. The mop machine was used during the night and a was used during the day. She also stated that both were done twice daily. The surveyor showed her a few doorways on the 400 hallway and she stated this is from wax. She further stated We are in the process of stripping and re waxing the floors. This will come up with floor stripper. This is from years of wax on top of wax. It should've been stripped before waxing. The floors have been waxed once in past 3 years. When asked for a policy regarding the floors, she stated she has never seen one. On 7/25/24 at 10:34 AM, the surveyor observed the shower room on the 400 wing with items on the floor including a used towel, used gloves, a clothing item and a used mask. There was also noted an opened adult brief on a shower chair. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 Birchwood Ave Cranford, NJ 07016	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 10:40 AM, the surveyor interviewed a CNA who was shown the shower room. She stated, this is not what is supposed to be. She stated that when someone gives a shower, the CNA should clean up after done with shower. On 7/25/24 at 10:43 AM, the surveyor interviewed an LPN who was shown the shower room and stated that's terrible, it's unacceptable. She further stated that when finished with a shower, the CNA should clean up afterward. She stated she was not sure how often the shower room is checked. She further stated that housekeeping cleans the shower room, but she was not sure how often. On 7/25/24 at 11:00 AM, the surveyor interviewed the Director of Housekeeping, regarding the dark areas on the floor and the tiles. She stated that it is probably from old. She further stated, this is clean as its going to get. When asked if she would want to take a shower on that shower stall, she stated no. She also stated that she tries to check the shower room twice a day. She further stated that maybe it needs new tiles and caulking. A loose tile was noted. On 7/25/24 at 12:04 PM, the surveyor interviewed the maintenance director, regarding the 400 wing shower room. He stated he does rounds monthly and walks through weekly to see what he could see. He further stated that he was in that room earlier this week to fix a broken tile near scale. He also stated he did not see tile in photo. He stated the brown stuff is housekeeping, and that it is not acceptable, and should've been scrubbed. On 7/25/24 at 1:33 PM, the surveyor interviewed the Administrator who stated they are working on the floors and doorways on the weekends. On 7/26/24 at 9:51 AM, the surveyor observed doorways on 400 hallway show faded areas where dark dirty areas were noted previously. The shower room on the 400 hallway noted with new caulking and broken tile replaced. Dark brown areas still noted in the shower stall. On 7/26/24 at 10:16 AM, the surveyor interviewed the Administrator regarding 400 wing shower room. Shown a photo and asked if the work was completed in the shower room. He stated he would check on it. On 7/26/24 at 11:31 AM, the surveyor interviewed the Director of Nursing who stated she reminded the staff to keep the shower rooms clean and tidy and housekeeping to clean. The Administrator stated, we are finishing up that shower room. N.J.A.C. 8:39-31.4 (a) (f)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 19106 NJ 00167683 NJ 00172468 Repeat Deficiency Based on observation, interview, and record review it was determined that the facility failed to ensure the accurate assessment of residents using the Minimum Data Set (MDS) assessment tool. The deficient practice was identified for 3 of 34 residents (#94, 37, 586) reviewed for MDS accuracy and is evidenced by the following. 1. The surveyor observed Resident #94 on 7/23/24 at 11:58 AM, lying in bed with eyes closed. A review of the hybrid medical record revealed the resident was admitted with diagnoses including but not limited to cerebral infarction, gastrostomy, and seizure disorder. Wound Care Consultant reports from 5/6/24 through 7/22/24 documented chronic moisture associated skin damage (MASD) of the sacral area. Section M - Skin Conditions of the 7/14/24 annual MDS indicated the resident had no skin conditions (pressure ulcers, other ulcers, wounds and skin problems). Section M1040 - H MASD (incontinence associated dermatitis) was unchecked to indicate MASD was not present during the assessment reference date of 7/14/24. On 7/24/24 at 11:00 AM, the surveyor interviewed the MDS Coordinator. She stated the 6/14/24 quarterly MDS Section M1040; H. MASD should have reflected that the resident had MASD. She stated a correction MDS would be done immediately. The corrected MDS was provided to the surveyor. On 7/24/24 at 2:10 PM, the surveyor discussed the MDS inaccuracy with the Director of Nursing and the Administrator. 48964 2. The surveyor observed resident #37 on 7/23/24 at 11:45 AM, sitting in a chair in room next to the bed with call bell within reach. A review of the hybrid medical record revealed the resident was admitted with diagnoses including but not limited to anemia (low levels of red blood cells), hypertension (high blood pressure), and rectal cancer. The care plans included anemia related to disease process: colon/duodenum cancer, I have duodenum/rectal cancer, and risk of pain related to history of malignant neoplasm of duodenum and rectum. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A consult dated 6/12/24 indicated there were no plans for chemo, resident hospice appropriate, but not ready yet. A consult dated 2/21/24 indicated iron deficiency anemia / rectal cancer follow up. Section I - Active Diagnoses of the 5/17/24 annual MDS indicated the resident did not have cancer. Section I0100 - Cancer was not checked, nor was it included in I8000 indicating cancer was not an active diagnosis during the assessment reference date of 5/17/24. On 7/24/24 at 2:10 PM, the surveyor discussed the MDS inaccuracy with the Director of Nursing and the Administrator. On 07/25/24 at 9:16 AM, the surveyor interviewed the MDS Coordinator. She stated the cancer diagnosis should have been coded, indicating the resident had cancer. She stated she would modify the MDS. 3. A review of the electronic medical record revealed Resident #586 was admitted with diagnoses including but not limited to hypertension (high blood pressure and Alzheimer's disease (a progressive disease that impairs memory and other functions). Progress notes indicated that on 3/21/24 it was noted that the resident was unable to ambulate. An x-ray was completed, and a left femur fracture was noted. A review of facility reported investigation dated 3/26/24 indicated the conclusion was that fracture was the result of an unwitnessed fall by the resident. Section J - Health conditions of the 3/26/24 discharge MDS indicated the resident had no falls since the prior MDS assessment. Section J1800 was coded 0, indicating no falls since the prior assessment. On 7/24/24 at 2:10 PM, the surveyor discussed the MDS inaccuracy with the Director of Nursing and the Administrator. On 7/25/24 at 9:20 AM, the surveyor interviewed the MDS Coordinator regarding the conclusion of the investigation that an unwitnessed fall caused the fracture and the coding of the MDS. She stated that she will check with her regional about the fall and get back to me on their decision. On 7/26/24 at 11:13 AM, the MDS Coordinator stated that she was modifying the discharge MDS to include the fall. N.J.A.C 8:39-11.1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34421 Based on observation, interview and record review, it was determined that the facility failed to develop a comprehensive care plan to address the anticoagulant medication prescribed for 1 of 3 residents (Resident # 115) reviewed for anticoagulant medications and evidence by the following: On 7/22/24 at 12:54 PM, the surveyor observed Resident #115 in room and the resident stated takes an anticoagulant medication. The surveyor reviewed the Electronic Medical Records for Resident # 115 that revealed the following: According to the Admission Record indicated that Resident # 115 was admitted with diagnoses that included Atrial Fibrillation. According to the Physician's Order Summary Sheet, the resident had the following physician's order for by mouth administration of medications: -Apixaban Tablet (a medication which thins the blood and is used to reduce the risk of stroke and heart attack) 2.5 mg 1 tablet by mouth every two days. The surveyor reviewed the resident's care plans and observed that there was no care plan to address the care needs for Resident #115 with an anticoagulant. On 7/25/24 at 11:03 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the Unit Manager completes the care plans and that there should be a care plan in place for this resident who receives anticoagulant medication. The LPN stated that she was not sure why there was no care plan created. On 7/25/24 at 1:16 PM, the surveyor discussed the above concern with the Administrator and Director of Nursing. No additional information was provided. NJAC 8:39-11.2 (e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint # 173271 Based on interview, record review and review of pertinent facility documentation it was determined that the facility failed to a.) thoroughly assess a skin discoloration that was identified on an admission assessment and, b.) implement a care plan for a resident identified as a high risk for skin breakdown. This deficient practice was identified for 1 of 4 residents (Resident #585) reviewed for pressure ulcers and was evidenced by the following: According to the Admission Record, Resident #585 was admitted to the facility with the diagnoses which included but was not limited to; spinal stenosis cervical region, muscle wasting and atrophy and type two (2) diabetes mellitus. The admission Minimum Data Set (MDS), an assessment tool that facilitates a resident's care dated 3/29/24, reflected that the resident was frequently incontinent of bladder and bowel and required maximum assistance with activities of daily living (ADLs). The MDS also reflected that the resident was at risk for developing pressure ulcer and injuries and had no skin or ulcer injury treatments. Review of the Nurses Notes dated 3/22/2024 at 23:29 (11:29 PM) indicated that the resident was admitted from the hospital to the facility and was incontinent of bladder and bowel and had no wounds. Review of the Admission Assessment (AA) dated 3/22/24 at 19:48 (07:48 PM) indicated that the resident had discolorations on the groin and sacrum. There was no size, color or description of the discoloration documented in the medical record. The AA also reflected that the resident was always incontinent of bladder and bowel. The Braden scale (the most frequently used pressure injury risk assessment tool in the United States) was completed on the AA dated 3/22/24 which revealed the following: The resident scored a 12 on the BS and if the total score was 12 or lower, the resident should be considered at high risk for skin breakdown. The AA indicated that prevention protocol should be initiated immediately and documented on the care plan. The AA indicated that the following intervention would be implement on the CP: turn and reposition, apply moisture barrier with incontinence care, wheelchair cushion, change bedding as needed, and to monitor nutrition/hydration status. Review of Resident #585 care plan (CP) revealed that a CP was not implemented for potential for skin breakdown and no skin prevention interventions were put in place to prevent deterioration of the resident's skin. Review of the Treatment Administration Record (TAR) dated 3/1/24-3/31/24, the surveyor could not find any documentation any preventive protective skin care treatments were ordered by the physician. The TAR dated 3/26/24 at 7:00 AM, reflected a physician's order for weekly skin checks to be completed under the assessment area in the electronic medical record (EMR). The nurse signed the TAR indicating that the residents skin check was completed, however there was no documentation on the assessment section of the EMR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 11:20 AM, the surveyor interviewed the facilities wound care nurse who identified herself as a Licensed Practical Nurse (LPN). The LPN explained that her responsibilities included all wound care in the facility and that she performed all treatments in the facility from Monday through Friday. The LPN/Wound Care nurse stated that when the nurse completed and admission assessment and identified that the resident was at risk for skin breakdown, the nurse would be responsible to initiate the care plan with interventions to prevent deterioration of the skin. She continued to explain that any skin impairments or discolorations were to be described on the assessment such as color and size. On 7/23/24 at 11:41 AM, the surveyor interviewed the Director of Nursing (DON), reviewed Resident #585's AA dated 3/22/24 with the surveyor and confirmed that the AA indicated that the resident had discoloration on the groin and sacral area. The DON stated that the nurse should have been more descriptive on the admission assessment to include the color and size of the skin impairment. The DON also confirmed that when the resident was identified as a high risk for skin breakdown on admission, a CP should have been implemented with interventions to prevent skin breakdown. She confirmed that a CP was not implemented at that time. On 7/24/24 at 11:06 AM, the surveyor interviewed a Registered Nurse Unit Manager (RN/UN) who stated that standard skin care practice in the facility included antipressure relieving mattresses, skin protectant cream to be applied as needed for skin protection (do not need a physician's order) turning and repositioning every two hours, and frequent skin checks. She stated that if a resident was identified as a risk for breakdown on admission to the facility a CP should be initiated to include all skin breakdown prevention interventions. She explained that the interdisciplinary team wound also be notified that a resident was admitted to the facility and was at risk for breakdown. She added that the wound care team would also be notified if a resident had any discolorations so that they could determine a cause and identify the type of skin issue the resident had. She stated this would help to determine the appropriate interventions that would need to be initiated on the CP. On 7/24/24 at 11:13 AM, the surveyor interviewed and Certified Nursing Assistant (CNA #1) who has been employed in the facility for [AGE] years. She stated that standard skin care in the facility wound include application of protective skin care cream. She stated that the cream would only be applied if the resident was at risk for skin breakdown or was incontinent of bladder and bowel. She stated that she did not think that a physician's order was required for this type of care. She stated that the cream was only applied for protection. She continued to explain that incontinent resident required changing more frequently and that the staff were required to turn the residents every two hours. She stated that she was unsure if the mattresses utilized in the facility were antipressure mattresses. On 7/24/24 at 11:20 AM, the surveyor interviewed CNA #2 who had been employed in the facility for 3 years. She stated that if a resident was incontinent, they were changed frequently, and zinc oxide could be applied as needed to protect the resident's skin. She stated that if a resident had any skin impairments or discolorations it would be reported to the nurse and the nurse would be responsible to order treatments, write a CP and consult the wound care team. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 11:24 AM, the surveyor interviewed a Licensed Practical Nurse Unit Manager (LPN/UM) who explained that if a resident was admitted with a discoloration on the buttocks, a detailed description should be documented. A discoloration could be anything. She stated that skin assessments were done weekly on the electronic medical record under skin assessments. She stated that a CP with interventions to prevent breakdown should be initiated if a resident was identified as a high risk for breakdown. She explained that all mattresses in the facility were antipressure mattresses and that house stock zinc oxide was applied by the CNAs as a preventative treatment when a resident was incontinent of bowel and bladder. On 7/24/24 at 2:08 PM, the DON stated that the admission nurse should have described the wound in better detail such as color and size when the nurse completed the admission assessment. She stated that a second skin check was usually conducted on day two and the nurse should have put in a physicians order for the second skin check. On 7/25/24 at 8:30 AM, the surveyor interviewed the DON who explained that when a nurse completed the weekly skin checks, the nurse needed to go into the assessment section of the EMR to complete the documentation describing the resident's skin. The DON reviewed Resident 585's medical record in the presence of the surveyor and stated that this was not completed as per facility protocol on 03/26/24. On 7/25/24 at 8:30 AM, the surveyor interviewed the DON who explained that when a nurse completed the weekly skin checks, the nurse needed to go into the assessment section of the EMR to complete the documentation describing the resident's skin. The DON reviewed Resident 585's medical record in the presence of the surveyor and stated that this was not completed as per facility protocol on 3/26/24. On 7/25/24 at 10:09 AM, the surveyor interviewed the LPN #3 that performed the AA dated 3/22/24. LPN #3 stated that when she observed the discoloration on Resident #585's sacrum she should have documented the color and size of the discoloration. She also stated that a CP should have been implemented for potential for skin impairment with interventions to prevent skin breakdown, especially since the resident was a high risk for skin breakdown. On 7/25/24 at 10:31 AM, the surveyor interviewed the Registered Nurse (RN) who stated that she had been employed in the facility for approximately 5 (five) years. The RN stated that when she performed the skin assessment for Resident #585 on 03/26/24, she forgot to complete the skin assessment. The RN stated that had recollection that the resident had a skin discoloration on the sacral area. She stated that she must have overlooked that she was supposed to complete the skin assessment in the EMR. She stated that it would have been important to complete the skin assessment because it would give a more detailed picture of what the discoloration looked like. She stated that the resident frequently refused to be turned and repositioned and that the resident had skin prevention interventions. She stated that it would have been important to initiate a Care Plan for the resident to include all preventive skin interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 Birchwood Ave Cranford, NJ 07016	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Pressure Injury Prevention and Management with a revised date of 11/29/23 that the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and development of additional pressure ulcers/injuries. -The policy specified that licensed nurses would conduct a pressure risk injury assessment on all residents upon admission/readmission, weekly times four weeks, then quarterly. -Licensed Nurses would conduct a full body skin assessment on all residents upon admission/readmission, weekly and after any newly identified pressure injury and findings would be documented in the medical record. -After completing a thorough assessment, the interdisciplinary team shall develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions. Care plan interventions would be based on specific factors identified in the risk assessment, skin assessment and any pressure ulcer assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging and wound characteristics). The facility policy titled, Baseline Care Plan with a revised date of 9/18/23 reflected that a baseline care plan would be developed within 48 hours of a resident admission. Interventions shall be initiated that address the resident's current needs including: pressure ulcer risk. NJAC 8:39-27.1 (e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe, appropriate dialysis care/services for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48781

Based on observation, interview, and record review, it was determined that the facility failed to assess for complications upon residents' return from the renal dialysis (RD) center for 2 of 5 residents (Resident #55 and Resident #146) reviewed for dialysis care.

The deficient practice was evidenced by the following:

1. On 7/22/24 at 11:07, AM the surveyor observed Resident #55 lying in bed with the television on, wearing glasses, call light within reach. The resident stated, I go to dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) M-W-F, but I refused to go today because I don't feel good. I usually get my medication and meal before I leave for dialysis. I have my access on left arm and the nurses checks on this at times.

A review of the medical record revealed the following information: The Resident #55 had a diagnosis of but not limited to end stage renal disease (esrd); dependence on renal dialysis. End stage renal disease is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life.

A review of the order summary in the electronic health record (EHR) revealed orders for: Dialysis treatment 3 times a week on Mon, Wed, Fri at 10:00am. Pick-up at 9:45am, one time a day every Mon, Wed, Fri; Monitor dialysis access site Left Arm for signs & symptoms of bleeding, infection and pain every shift. Notify provider if abnormal findings and document in progress note every shift; AV (arterial venous) Fistula Left Arm, monitor bruit/thrill every shift, report any abnormal findings to medical doctor (MD).

A review of the Quarterly Minimum Data Sheet (MDS), an assessment tool used to facilitate the management of care, dated 5/17/24 reflected the Resident #55 had a brief interview for mental status (BIMS) score of 3 out of 15, indicating the resident had severe impaired cognition.

The RD Care Plan initiated on 1/12/24 instructed nursing staff to monitor AV fistula for a bruit, thrill, signs of infection, bleeding, patency, etc. Refer to MD as needed.

On 7/24/24 at 12:15 PM, the surveyor interviewed the registered nurse (RN) in Unit 3, who has been working at the facility for [AGE] years, who stated, Resident #55 was in the hospital a couple of times because resident refused dialysis at least 4x a month and was sent out to hospital due to refusing dialysis. This is resident's typical self, and all the doctors are aware. The resident goes to dialysis M-W-F.

A review of the nurses' progress notes for post dialysis access site assessment when resident was agreeable to go to dialysis, revealed inconsistent nursing assessment done from 5/17/2024 through 7/26/24 (two months-18 days total). The missing nursing documentations for post dialysis access site assessment were: 5/17/24; 5/27; 5/31; 6/10; 6/12; 6/14; 6/17; 6/19; 6/24; 6/26; 6/28; 7/3; 7/5; 7/15; 7/17; 7/19; 7/24; and 7/26.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 7/22/24 at 10:20 AM, the surveyor observed Resident #146 lying in bed, appears neat and dressed, call light within reach. The resident stated, I have an access on my left arm for dialysis, I'm supposed to go today. A review of the medical records for Resident #146 revealed diagnosis but not limited to: end stage renal disease and dependence on renal dialysis. The order summary revealed: Continue to monitor Dialysis Access site wound every shift for bleeding; Dialysis treatment 3 times a week on Tu/Th/Sat; L-arm AV Shunt, monitor shunt for s/s of infection, bleeding, bruit/thrill every shift. NO BP ON LEFT ARM, Monitoring Report any abnormal findings to MD; Monitor left arm for signs & symptoms of bleeding, infection and pain every shift every shift ordered 3/6/24. The Quarterly MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. Care plan dated 2/23/24 reflected to monitor AV fistula. A review of the nursing progress notes revealed the resident received renal dialysis on T-TH-Saturdays and then changed to M-W-F on 7/22/24. The surveyor reviewed nurses progress notes for post dialysis access site assessment which revealed inconsistent nursing assessment done from April 2024 through 7/19/24 (three months-32 days total). The nursing progress notes revealed missing documentation for post dialysis access site assessment for the dates of: 4/20/24, 4/23, 4/25, 4/27, 4/30, 5/2, 5/7, 5/11, 5/14, 5/16, 5/18, 5/21, 5/23, 5/25, 5/30, 6/1, 6/4, 6/6, 6/8, 6/13, 6/15, 6/18, 6/22, 6/27, 7/2, 7/4, 7/6, 7/9, 7/11, 7/18, 7/22, and 7/24/24. On 7/24/24 at 2:15 PM, the surveyor interviewed the director of nursing (DON), who has been working in the facility since last October of 2023, in the presence of the Licensed Nursing Home Administration (LNHA) and the survey team regarding the Dialysis Communication Worksheet to clarify pre and post dialysis access site evaluations. The worksheet did not include post dialysis assessments. Requested the DON to provide additional documentation for access site assessments by nursing staff. On 7/25/24 at 8: 45 AM, the DON provided documentation of Dialysis Worksheet for pre assessment of dialysis access for residents but did not provide documentation for post dialysis access site assessments. The DON stated in the presence of another surveyor, The documentation in this place is really bad. The post dialysis access site assessment documentation should be in the nursing progress notes in the computer if the nurses did them. On 7/25/24 at 11:03 AM, interviewed the RN who stated, The process is you have to check the dialysis site every shift for drainage, bruit, thrill and bleeding, and we also check it before and after dialysis and document in the computer. I don't see any post dialysis access site assessment documentation for the Resident #55 in the EHR for the last few weeks and Resident #146, I see one time documentation in progress notes for 6/25/24 only. The RN acknowledged that there should be documentation every time the resident comes back after dialysis. On 7/25/24 at 1:30 PM, the surveyor discussed findings and concern with post dialysis site nursing assessment, in the presence of the survey team, the DON, LNHA and the Regional Director of Operations. No additional documents were provided by the facility. A review of the facility policy and procedure titled Hemodialysis with a revision date of 3/2024 revealed, The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.1(a); 2.9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 34421 Based on observation, interview and record review, it was determined that the facility failed to ensure that the physician signed and dated monthly medication orders. The deficient practice was identified for 5 of 34 residents reviewed (#2, 84, 115, 32 and 33) and occurred over a 3 month period. The deficient practice was evidenced by the following. 1. A review of the hybrid medical record for Resident # 2 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April, May or June 2024. 2. A review of the hybrid medical record for Resident # 84 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April, May or June 2024. 3. A review of the hybrid medical record for Resident # 115 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April, May or June 2024. 19106 4. A review of the hybrid medical record for Resident #32 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April or June 2024. 5. A review of the hybrid medical record for Resident #33 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for April, May or June 2024. On 7/26/24 at 10:51 AM, the Wing 2 Unit Manager stated to the surveyor that the physicians should sign their monthly orders electronically. On 7/26/24 at 12:49 PM, the surveyor discussed with the Director of Nursing (DON) and the Administrator concerns of physicians not signing their monthly orders. The DON stated the physicians should be signing orders electronically. NJAC 8:39-23.2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48781 Based on observation, interview, and record review, it was determined that the facility failed to provide pharmaceutical services by ensuring the accurate administration of a medication, Midodrine, (medication used to increase the blood pressure), according to the physician's order to meet the needs of the resident. The deficient practice was identified for one (1) of 34 residents, (Resident #55) reviewed for medication management. The deficient practice was evidenced by the following: On 7/22/24 at 11:07 AM, the surveyor observed the Resident #55 in the Unit 3 North Wing in their room, lying in bed with the television on, wearing glasses, and call light within reach. On 7/24/24 at 9:34 AM, the surveyor reviewed the electronic health records (EHR) for Resident #55 which revealed diagnosis that included but not limited to hypotension, the pressure of blood circulating around the body is lower than normal. Blood pressure (BP) is the pressure of blood on the walls of your arteries as your heart pumps blood around your body. A review of the Quarterly Minimum Data Sheet (MDS), an assessment tool used to facilitate the management of care, dated 5/17/24 reflected the resident had a brief interview for mental status (BIMS) score of 3 out of 15, indicating the resident had severe impaired cognition. A review of the resident's Order Summary Report reflected a physician's order dated 5/10/24 for Midodrine HCl Oral Tablet 5 MG (Midodrine Hydrochloride) Give 1 tablet by mouth at bedtime for Hypotension Hold for SBP>130. The systolic blood pressure (SBP) is the first number, it is the pressure caused by your heart contracting and pushing out blood. A review of the electronic medication administration (eMARS) from April 2024 through July 2024 (three months) revealed Midodrine HCL was administered and not held for parameters of SBP>130 as ordered for: April 2024, received 13 dosages (4/1, 3, 4, 5, 9, 12, 13, 14, 15, 16, 17, 18, 19}; May 2024 received 11 dosages (5/12, 13, 15, 16, 18, 20, 21, 22, 23, 25, 30); June 2024 received 15 dosages (6/1, 5, 7, 8, 9, 10, 14, 17, 18, 19, 20, 21, 22, 26, 28); and on July 2024, received 17 dosages (7/2,, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 16, 19, 21, 23, 24). A review of the resident's blood pressure at its highest revealed the resident's BP on 5/18/24 was 172/81 and on 7/12/24 BPwas 168/71. The resident had no indication of a negative outcome from Midodrine administration when given above the parameter of SBP >130 during those times. Reviewed the primary physician's progress notes dated 7/15/24 who stated, Reviewed medications and vital signs with no changes. On 7/25/24 at 11:13 AM, the surveyor interviewed the registered nurse (RN) from Unit 3 North Wing who has been working in the facility for [AGE] years. She stated, The evening nurse should have held the Midodrine medication at night because the SBP is above 130. The nurse didn't pay attention because you can make the blood pressure go higher. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/25/24 at 11:35 AM, interviewed the Unit 3 Unit Manager (UM), who has been working in the facility for five months. The UM stated, The Midodrine should had been held when the SBP was above 130 as ordered. I see that it was the evening shift nurse who has been giving it. The resident has had no problems with his BP or had complained to me that he doesn't feel well. On 7/25/24 at 1:30 PM, in the presence of the survey team, the surveyor discussed findings with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA) and the Regional Director of Operations regarding the concern of Midodrine administration outside the SBP parameters. On 7/26/24 at 8:48 AM, interviewed the 3-11 shift Licensed Practical Nurse (LPN), regarding Midodrine administration on his shift. The LPN stated, Midodrine is a medication for a low blood pressure. The resident sometimes has a low or high BP. I take the BP to make sure it's in range before giving it. I've been making mistakes in the computer; I've been holding the medication, but I didn't know that I had to go back to strike it out. The DON showed me yesterday how to hold it in the computer. I didn't know I had to document in the progress notes if I held a medication. I've been working with this EHR for about three years. If I sign a medication, it means it was given, but I made a mistake with the Midodrine on how to cancel it in this EHR. I've been working in the facility for four years. I didn't know I had to notify anyone when a medication has been held for a couple of times. On 7/26/24 at 10:30 AM, the surveyor received from the DON, the Scriptive Consultants Medication Administration Observation competencies for the LPN dated 5/24/23, 2/5/24 and 7/25/24 which revealed competencies for blood pressure check and cautionaries for the preparation and administration of medications were met by the LPN. On 7/26/24 at 10:40 AM, interviewed the registered pharmacy consultant (RPH), who has been a consultant in the facility for four years, stated, They get their Medication Review Report (MRR) once monthly. We follow up a month later to make sure it was done. If it was a med error, we call them up to look into it. If I get the report again the next month, the facility needs to follow it up, that's the expectation. A review of the Consultant Pharmacist's MRR dated 5/19/24, and 6/25/24 revealed Midodrine was signed numerous times as given when it should have been held for SBP >130. Please reevaluate the resident's need for Midodrine and consider discontinuing. On 7/26/24 at 11: AM, the surveyor in the presence of the survey team discussed with the DON the MRR process and recommendations above and she stated, The unit manager follows through the MRR recommendations, unfortunately in this case it fell through the cracks for the 5/19/24 and 6/25/24 MRR. I did speak to the LPN involved yesterday and he did not know how to work the screen of EHR, but the expectation is, if something is held for a few days, the LPN should have told his manager, the primary doctor and should have documented in the progress notes when medications were held. No additional documentation was provided by the facility. A review of the facility policy and procedure titled, Medication Administration revised on 6/7/24 revealed, Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. NJAC 8:39-29.2 (d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45208 Repeat Deficiency Based on observation, interview, and record review, it was determined that the facility failed to a.) store potentially hazardous foods (PHFs) in a manner to prevent food borne illness and b.) maintain kitchen equipment in a clean and sanitary manner as evidenced by the following: (PHFs) are foods that must be kept at certain temperatures to minimize the growth of pathogenic microorganisms that may be present in the food or to prevent the formation of toxins in the food. Generally, PHFs are moist, nutrient-rich and have a neutral ph.) On 7/24/24 at 10:05 AM in the presence of the Food Service Director (FSD) and the Administrator in training (AIT) the surveyor observed the following: 1. The surveyor and FSD went into the walk-in freezer, during observation it was noted that there were sheets of ice on the floor, icicles hanging from the ceiling, the condenser fans and food boxes. The kitchen supervisor was actively scraping the ice off the floor with a long-handled ice scraper. 2. In the walk-in freezer, the surveyor observed several boxes of opened, not labeled with open or expiration dates, and unsealed food items. The items are as follows: croissants, turkey burgers, and breaded eggplant. All the items in the freezer were covered with snow, frost, and ice crystals. 3. On 7/22/24 at 10:18, the surveyor observed that the walk-in refrigerator #1 had inconsistent temperature readings from 3 different thermometers. ~44 degrees Fahrenheit (F) interior built in thermometer, ~46 degrees F, exterior built in thermometer, ~42 degrees F, portable interior thermometer, ~Survey reviewed Refrigerator #1 temperature log which revealed a written temperature of 36 degrees F on 7/21/24 at 730pm. 4. Further observations in Refrigerator #1 by the surveyor was a box of bacon that was opened, unsealed and unlabeled. 5. Walk-in refrigerator #2, was out of service and not working, upon surveyor entry on 7/22/24 there was not a plan for it to be repaired. Surveyor reviewed service order # 4548236, dated 6/26/24 and two emails dated 6/26/24 and post survey team entry on 7/23/24. All three indicated communication FROM the repair service. There were NOT any emails or documents provided to the surveyor indicating correspondence FROM the facility or that repairs were in the process of being initiated or waiting for parts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. On 07/22/24 at 01:17 PM, the FSD, Surveyor #1 and Surveyor #2 took temperatures of 2 items in walk-in refrigerator #1. FSD stated that the kitchen thermometers had been calibrated. ~Heavy Cream: 1 liter container, The FSD inserted the calibrated thermometer into the center of the container, it read 46.7 degrees F. ~Cottage Cheese: 32-ounce container. The FSD inserted the calibrated thermometer straight down in the center of the container. The temperature read 50.4 degrees F with the first thermometer. The FSD inserted a second calibrated thermometer that read 49.4 degrees F. 7. The microwave interior ceiling was covered with multi-color splatter debris. The FSD acknowledged that it had not been cleaned correctly. 8. The meat slicer was covered in a plastic bag which the FSD indicated it meant that it was clean. Upon removal of the bag the slicer pusher spikes were soiled with caked on brown debris. The FSD stated that it should have been cleaned and then covered with the bag. 9. The shelf under the griddle had sediment and debris. The FSD acknowledged it had not been clean thoroughly. On 7/22/24 at 11:00 AM, the surveyor interviewed the FSD. who stated, the freezer items should have been labeled with an opening date and if only partial of a bag was used it should be resealed and labeled. He further stated, the cooking equipment should be cleaned and maintained in a sanitary way to prevent food borne illness and contamination. On 7/22/24 at 10:44 AM the surveyor interviewed the kitchen supervisor (KS), who stated, the ice and frost in the freezer is a reoccurring issue. He acknowledged that the frost and snow in the freezer and on the products can degrade the food quality and has the potential to cause food borne pathogens. On 7/22/24 at 11:26 AM, the surveyor interviewed the clinical dietary manager (CDM) who stated, the freezer has been an issue for last 4 months. It is discussed in morning meeting. On 7/24/24 at 10:33 AM, the surveyor interviewed the licensed nursing home administrator (LNHA) who stated, the refrigerators and freezer need to be in working condition because it can cause potentially hazardous food, food borne illnesses and degrades the quality of the food. I acknowledge what the survey team saw. A review of the policy titled, Food Safety Requirements Policy dated 4/9/24, which was provided by the LNHA read . Policy: Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Definition: food service safety refers to the handling, preparing, and storing food in ways that prevent food borne illness. Food borne illness refers to an illness caused by the ingestion of contaminated food or beverages. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER: Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 Birchwood Ave Cranford, NJ 07016	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy Explanation and Compliance Guidelines: #1-b) Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. e) Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food. #3-c) Refrigerated storage- foods that require refrigeration shall be refrigerated immediately upon receipt or placed in the freezer whichever is applicable. Practices to maintain safe refrigerated storage include: iv.) labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used-by date, or frozen (where applicable) /discarded. v.) Keeping food covered or in tight containers. #6) all equipment used in the handling of food shall be cleaned and sanitized and handled in a manner to prevent contamination. a) Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. #8) Additional strategies to prevent foodborne illness include but are not limited to: d) Proper refrigeration of meat, poultry, and pasteurized dairy products. A review of the policy titled, Physical Environment: Electrical Equipment dated 7/2024, which was provided by the LNHA read . #4) Essential equipment shall be repaired or replaced as soon as practicable. e) Kitchen refrigerator /freezer. A review of the policy titled, Monitoring of Cooler / Freezer Temperature dated 7/2024, which was provided by the LNHA read . Policy: It is the policy of this facility to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. Policy Explanation and Compliance Guidelines: #2) Thermometers shall be placed inside each cooler/ freezer and calibrated at least once per week. #3) All refrigerated storage must be maintained at or below 41 degrees F, unless otherwise specified by law. #5) If temperatures are above 41 degrees F for coolers or 10 degrees F for freezer, the supervisor will be notified immediately for corrective action. a) The unit will be repaired as soon as possible. If the problem cannot be corrected within 2 hours, all food items will be relocated to another unit that can hold foods in an acceptable temperature range. b) Internal temperature readings of all perishables of potentially hazardous food shall be taken and discarded if not in an acceptable range. 11) Refrigerated food shall be labeled, dated, and monitored so that it is used by the use-by date, frozen or discarded, whichever is applicable NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 REPEAT DEFICIENCY Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) minimize the potential spread of infection to residents during medication administration for 1 of 2 nurses observed during medication pass on 1of 2 units (Unit 3 Low side) and b.) follow Center for Disease Control recommendations and guidelines for Hand Hygiene. This deficient practice was evidenced by the following: On 7/24/24 at 7:56 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN) prepare medication for administration to an unsampled resident in room [ROOM NUMBER]. The RN opened the drawer of the medication cart, retrieved the blister packs (multi-use medication packs), and removed the medications amlodipine besylate10mg tablet, colace 100mg tablet and doxazosin mesylate 2mg tablet. The RN administered the medications, returned to the medication cart, opened the drawer, removed the blister packs from the cart, and utilized the computer to sign the electronic medical record (eMR) indicating the medications had been administered. The RN did not perform hand hygiene before preparation or after administration of the medications. On 7/24/24 at 8:06 AM, the surveyor observed the RN prepare medication for administration to Resident #47. The surveyor observed signage posted to the left of the entrance door to Resident #47's room which read: Enhanced Barrier Precautions STOP. Everyone must clean their hands before entering and exiting the room. Providers and staff must also wear gloves and gown during high-contact resident care activities. The surveyor observed the RN open the drawer of the medication cart, retrieve the blister packs and remove the medications duloxetine hcl 60mg caplet, furosemide 40mg tablet and vitamin C 500mg tab from the blister packs. The RN administered the medications, returned to the medication cart, opened the drawer, removed the blister packs from the cart, and utilized the computer to sign the eMR indicating the medications had been administered. The RN did not perform hand hygiene before preparation or after administration of the medications. On 7/24/24 at 8:14 AM, the surveyor observed the RN prepare medication for administration to Resident #117. The surveyor observed signage posted to the left of the entrance door to Resident 47's room which read: Enhanced Barrier Precautions [EBP] Stop. Everyone must clean their hands before entering and exiting the room. Providers and staff must also wear gloves and gown during high-contact resident care activities. The surveyor observed the RN opened the drawer of the medication cart, retrieved the blister packs and removed the medications buspirone 30mg tablet, citalopram 40mg tablet, Keppra 750mg tablet, clozapine 100mg tablet, colace 100mg tablet, from the blister packs. The RN administered the medications, returned to the medication cart, opened the drawer, removed the blister packs from the cart, and utilized the computer to sign the eMR indicating the medications had been administered. The RN did not perform hand hygiene before leaving Resident #117's room or after administration of the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation and Healthcare Center	205 Birchwood Ave Cranford, NJ 07016

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 8:27 AM, the surveyor discussed the breaks in technique with the RN. The RN stated that she had not performed hand hygiene during the medication administration because she didn't touch the residents. The surveyor asked the RN if she should perform hand hygiene before preparing medications and after handling the cups that the residents had also handled. The RN acknowledged that she should have performed hand hygiene before preparing medications and after administration of medications. The surveyor showed the EBP signage outside of Resident #47 and Resident #117's rooms. The RN acknowledged that she should have performed hand hygiene before entering and exiting a resident's room who was on EBP to prevent the spread of infection. The surveyor reviewed the facility policy titled, Medication Administration last reviewed 6/7/24, which revealed the following: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .wash hands prior to administering medication per facility protocol and product. The surveyor reviewed the facility policy titled, Enhanced Barrier Precautions last reviewed 3/20/24 which revealed the following: Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and gloves. 34421 2. On 7/22/24 at 02:00 PM, in a conference room inside the facility, the surveyor observed a House Keeper (HK) go to the sink to wash his hands. The surveyor observed the HK put soap on his hands and rubbed his hands together for 12 seconds, then, with his soapy hands, he turned the faucet on and rinsed his hands off. The surveyor observed the HK turn the faucet off with his bare hands and the surveyor observed the HK rub his hands directly onto his pants to dry his hands off. A review of the Hand Hygiene policy and procedure, dated 5/29/24, revealed that All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility .including between resident contacts .before preparing or handling medications. And, Hand Hygiene technique when using soap and water: wet hands with water, apply to the hands the amount of soap recommended by the manufacturer, rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, rinse hands with water, dry thoroughly with a single-use towel, use clean towel to turn off the faucet. On 7/24/24 at 2:00 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above observations. The DON acknowledged that the RN was expected to wash her hands or use Alcohol Based Hand Rub (ABHR) prior to handling medications, between residents and before entering and exiting resident rooms who were on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
NAME OF PROVIDER OR SUPPLIER Birchwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Birchwood Ave Cranford, NJ 07016	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/24 at 10:42 AM, the surveyor interviewed the Infection Preventionist (IP), who stated that the HK was recently educated on hand hygiene and should have known how to properly wash their hands according to CDC and facility policy. The IP also stated that nurses during medication pass should also be performing hand hygiene between residents, especially those who are on any type of precautions. According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers (HCP) for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included that the HCP should perform hand hygiene before and after direct contact with the residents and immediately after glove removal. In addition, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, and this should be done outside the water when rubbing your hands, then rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take approximately 20 seconds. NJAC 8:39-19.4 (a)