| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315124 | A. Building<br>B. Wing | 06/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Belle Care Nursing and Rehabilitation Center | 439 Bellevue Avenue<br>Trenton, NJ 08618 |

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Let each resident or the resident's legal representative access or purchase copies of all the resident's records.<br><br>38080<br><br>NJ Complaint #168809<br><br>Based on interviews and review of pertinent facility documents, it was determined that the facility failed to provide a discharged resident with a copy of their medical records within a timely manner of the written request. This deficient practice was identified for 1 of 1 resident reviewed for medical records (Resident #252), and was evidenced by the following:<br><br>According to the Resident Face Sheet (an admission summary), Resident #252 was admitted to the facility in 2022 with diagnoses kidney failure. The face sheet did not include the resident's discharge date .<br><br>A review of the electronic Admissions record revealed Resident #252 was discharged from the facility in July of 2022.<br><br>On 6/19/24 at 12:09 PM, the surveyor interviewed the Medical Records personnel who stated residents and authorized personnel can request medical records. Once the Medical Records personnel received the authorization, she printed out the medical records and had the nurses review to ensure they were complete and accurate. At that time the surveyor provided the Medical Records personnel with a list of residents if she could provide documentation if medical records were requested.<br><br>On 6/20/24 at 9:12 AM, the Medical Records personnel informed the surveyor that months ago a representative for Resident #252 requested a copy of the resident's medical records. The Medical Records personnel stated she had made copies and provided them to the previous Administrator, and she was unsure if he sent them to the representative for Resident #252. At that time, the surveyor requested a copy of the medical records request and any documentation the medical records were released.<br><br>A review of the documentation provided by the facility's Licensed Nursing Home Administrator (LNHA) revealed that on 10/27/23, a representative for Resident #252 made a request to receive a copy of the resident's medical records.<br><br>(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 |
|---|---|---|

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/25/24 at 10:33 AM, the surveyor interviewed the LNHA who stated the facility had a form that was to be completed and medical records were released. The LNHA stated a resident, family member, or representative as long as they were authorized could receive access to medical records with a small fee up to $20. The medical records were printed out as soon as possible after the request was made. The LNHA stated at the time of Resident #252's stay at the facility, the facility utilized paper medical records, and the facility was trying to locate the records.<br><br>On 6/25/24 at 1:22 PM, the LNHA informed the surveyor that there was no evidence that the representative for Resident #252 received the records.<br><br>A review of the facility provided Medical Record Policy dated last revised 5/1/24, did not include the process for obtaining medical records.<br><br>NJAC 8:39-35.2(h) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>38080<br><br>Complaint NJ #162168<br><br>Based on interviews, review of the closed medical records, and pertinent facility documents, it was determined that the facility failed to notify a resident's family after a change of condition. This deficient practice was identified for 1 of 35 sampled residents (Resident #247), and was evidenced by the following:<br><br>A review of the closed medical record for Resident #247 revealed the resident was admitted to the facility in 2019 and discharged from the facility in 2023.<br><br>A review of the Minimum Data Set (MDS), an assessment tool dated 2/3/23, indicated that the resident had unclear speech and usually understood with diagnoses which included hypertension, depression, bipolar, and schizophrenia.<br><br>A review of the Progress Notes included a Nurses Note (NN) dated 11/13/22, that the resident was noted sitting on the floor in their bathroom with no injuries. Vital signs were obtained, and the resident attempted to stand up from their wheelchair without assistance, and slipped on their feces that they spread around their bathroom. The nurse noted that they left a message for the physician, but they were unable to call a responsible party because there was no phone number available.<br><br>On 6/19/24 at 1:25 PM, the surveyor requested from the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) a change of condition policy.<br><br>On 6/20/24 at 9:54 AM, the surveyor interviewed the DON who stated family was notified anytime there was a change in condition. The surveyor asked the DON why there was no phone number for Resident #247's representative, and the DON stated the resident had a responsible party who was very involved in their care, and the Social Worker (SW) would be able to contact them. The facility's SW worked at the only one week, and the surveyor asked the DON to provide any documentation they were informed of the change in condition on 11/13/22.<br><br>On 6/20/24 at 12:57 PM, the survey team met with the LNHA and DON, and requested any additional information on Resident #247's change of condition notification. The DON stated that the resident had a responsible party who was very involved, and needed to check the Progress Notes. The surveyor requested a change of condition policy.<br><br>On 6/26/24 at 10:36 AM, the Assistant Director of Nursing (ADON) in the presence of the LNHA, DON, and survey team stated that she usually spoke to Resident #247's responsible party member via the telephone that she stored in a separate book, and the ADON always made sure the responsible party was aware of any changes. The ADON confirmed the phone number should have been located in the resident's medical record, and that Resident #247's responsible party should have been made aware of the resident's change of condition.<br><br>No policy was received.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | NJAC 8:39-13.1(c) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>38080<br><br>NJ Complaint #166562<br><br>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who was on one-to-one (1:1) monitoring by staff was constantly monitored by staff to ensure the resident was free from neglect when they sustained bruising to both ears and a lower spine fracture from an unwitnessed fall. The deficient practice was identified for 1 of 7 residents reviewed for abuse (Resident #254), and was evidenced by the following:<br><br>A review of the facility's One-to-One Observation policy and procedure, dated revised January 2024, included the aim of one-to-one nursing is to provide continuous observation for an individual patient for a period of time during acute physical or mental illness .Primary Physician/Nurse Practitioner shall be notified about the change in patient's condition and order will be obtained for continuous 1:1 observation until further evaluation. Resident/patient's care plan will be initiated and/or updated with resident centered interventions .<br><br>On 6/17/24 at 1:00 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a copy of investigations for reportable events to the New Jersey Department of Health (NJDOH) or any investigations that included injury of unknown origin or allegation of abuse and neglect for July and August 2023.<br><br>The surveyor reviewed an investigation for the closed medical record for Resident #254.<br><br>A review of the Incident Report dated 8/14/23 at 8:30 AM, revealed that the Assistant Director of Nursing (ADON) was called to Resident #254's room to assess the resident who had blue discoloration on both ears, a three centimeter by three centimeter (3 cm x 3 cm) abrasion to right knee; discoloration on right side of face and mid arm. When staff attempted to turn the resident over, the resident screamed in pain; the physician was made aware and a new order was put in place to send to the emergency room for evaluation. The report indicated no witnesses. Additional comments or steps taken to prevent recurrence included resident will be continuously monitored every shift on 1:1. A review of the statement dated 8/14/23, by the Registered Nurse (RN) included they were called to the resident's room and they observed the resident in bed with black and blue marks on right side of face. The resident was confused and unable to say what happened; upon further assessment noted multiple black and blue discoloration on both ears and right side of face. The resident complained of pain when an attempt to turn side to side was made, and the Supervisor was notified.<br><br>A review of the Emergency Department Discharge Note dated 8/14/23, included the resident had an acute fracture to the transverse process of the lumbar 3 (L3) and lumbar 4 (L4) on left side (lower spine fracture) with no significant abnormalities. There was no additional reports from the hospital provided.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of the individual comprehensive care plan (ICCP) included in the investigation, had a focus area dated effective 11/16/22, for behavior related to cognitive impairments; desire to manipulate; chronic mental illness; decline in medical condition; and mood state. Goal included to feel safe in my environment; resident to continue on 1:1 all shifts. A further review included a focus area dated effective 11/16/22, for falls due to medication use with an intervention that included to remain on 1:1 every shift.<br><br>A review of an additional Incident Report included in the investigation packet dated 8/14/23 at 7:00 PM, prepared by the ADON included that they saw the resident on the ground floor, and the ADON asked the resident about their bruise, and the resident stated they fell . The resident did not know when they fell .<br><br>A review of the Progress Notes included a Nursing Note (NN) dated 8/13/23 at 3:06 PM, that on arrival it was noted by the incoming 1:1 staff that the resident had an abrasion on their knee, because the resident was a poor historian, it was unknown how the abrasion got there. Resident alert and oriented to person, denied pain and on assessment no additional injuries noted except abrasion to right knee with no bleeding or discharge noted. This note indicated that the resident's abrasion was discovered on 8/13/23, and not on 8/14/23, as reported on the Incident Report dated 8/14/23 at 8:30 AM.<br><br>On 6/19/24 at 11:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated that Resident #254 was on a 1:1 monitoring and should have been monitored at all times so there should not have been an unwitnessed fall. The surveyor asked if staff was looked at for possible abuse, and the DON stated that usually the Certified Nursing Aide (CNA) was with the resident, and CNA #1 was looked at. The DON confirmed there were video cameras in the hallways, but could not speak to if the cameras were checked. At that time, the surveyor requested the resident's 1:1 monitoring logs for 8/13/23 and 8/14/23.<br><br>On 6/19/24 at 12:00 PM, the surveyor interviewed the ADON who stated she could not recall if the resident's incident occurred on Sunday (8/13/23) or Monday (8/14/23), but when they were in the building on 8/14/23, they were asked to assess the resident.<br><br>The surveyor continued to review the closed medical record for Resident #254.<br><br>A review of the Resident Face Sheet (admission summary) reflected the resident was admitted to the facility with diagnoses which included schizoeffective disorder, bipolar, and slipping, tripping, and stumbling without fall due to stepping from one level to another.<br><br>A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 5/16/23, reflected the resident usually understood, with difficulty communicating some words or finishing thoughts, but was able if prompted or given time and sometimes understands by responding adequately to simple, direct communication only. The MDS further reflected the resident transferred between surfaces including to or from bed, chair, wheelchair, standing position with one person physical assist and used a wheelchair.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 6/20/24 at 8:59 AM, the surveyor re-interviewed the ADON who stated she thought Resident #254 was placed on a 1:1 monitoring in April of 2023, because they were combative and a fall risk. The ADON stated they were still looking for the resident's 1:1 monitoring log from August 2023, but stated CNA #1 was their aide on 8/14/23. The ADON stated CNA #1 no longer worked at the facility, and the surveyor requested their phone number.<br><br>On 6/20/24 at 9:52 AM, the surveyor interviewed the DON who stated there was not necessarily a physician's order for 1:1 monitoring; that it was documented on the twenty-four hour nursing report and the shift-to-shift report; as well as the resident's care plan. The DON stated the physician was verbally made aware the resident was on 1:1 monitoring. There was no documentation in the medical record provided to confirm the physician was made aware or ordered 1:1 monitoring.<br><br>On 6/20/24 at 10:12 AM, the surveyor asked the DON what the facility's process for investigating was, and the DON stated staff was interviewed and statements were obtained, resident was spoken to, and any additional witnesses. The facility investigated skin tears, injuries of unknown origin, fractures of unknown origin, complaints, verbal, physical, and sexual abuse. The DON stated they gathered statements from staff for 72 hours prior to incident of unknown origin, and the investigation was started immediately. After statements were gathered and the resident was assessed, the statements were reviewed to determined what occurred; if abuse was substantiated; and what interventions could be put into place to prevent the situation from occurring again. Review of the investigation provided by the facility dated 8/14/23, revealed that the skin abrasion discovered on 8/13/23, was not immediately investigated until further injury was discovered on 8/14/23. The investigation also did not include how the resident who was on 1:1 monitoring had an unwitnessed fall that resulted in bruising and a fractured spine.<br><br>On 6/20/24 at 11:30 AM, the surveyor requested from the ADON again for CNA #1's phone number.<br><br>On 6/20/24 at 12:17 PM, the surveyor observed CNA #2 and CNA #3 outside of two resident rooms. Both aides confirmed the residents in the rooms were on 1:1 monitoring; and they both confirmed that someone stayed with the resident at all times, and every hour another aide would come to switch with them. They both confirmed the resident was never left alone.<br><br>On 6/20/24 at 1:24 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), and the DON. The surveyor informed them that they were still waiting for the resident's 1:1 monitoring sheets from August 2023, and they also requested additional information regarding why the Progress Notes documented the resident had a skin abrasion on their right knee on 8/13/24, but it was not investigated until 8/14/23, when the resident was observed with not only the skin abrasion, but two bruised ears. The surveyor also asked for additional information on how a resident who was on 1:1 monitoring had an unwitnessed fall that resulted in two bruised ears and a fractured back. At that time, the LNHA acknowledged that the investigation should have included how the resident who was on a 1:1 monitoring had an unwitnessed fall.<br><br>On 6/25/24 at 1:28 PM, the surveyor requested from the LNHA and DON again the 1:1 monitoring sheets for Resident #254 for August 2023.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 6/26/24 at 9:45 AM, the surveyor reviewed the 1:1 monitoring logs for Resident #254 for 8/13/23 and 8/14/23. The log indicated that CNA #1 was monitoring the resident on 8/13/23 from 7:00 AM through 11:00 PM; CNA #4 and #5 monitored from 8/13/23 at 11:00 PM until 8/14/23 at 7:00 AM; and CNA #6 monitored the resident on 8/14/23 from 7:00 AM until 11 PM. A review of CNA #6's statement from 8/14/23, indicated that at around 8:00 AM on that day, they entered the resident's room to do morning care, and the resident was in bed laying on their back, and the aide noticed black and blue marks on both ears and they called the nurse. CNA #6's statement that they saw the resident at 8:00 AM for care contradicted the 1:1 assignment that indicated CNA #6 was with the resident from 7:00 AM until 11:00 PM on 8/14/23.<br><br>A review of the 8/13/23 11:00 PM to 7:00 AM Certified Nursing Assistant Assignment Schedule reflected that CNA #4 and #5 both had resident assignments that night as well as an assignment of 1:1 with Resident #254.<br><br>A review of CNA #4's statement dated 8/13/23, indicated that they took care of the resident on 8/13/23, during the 11:00 PM to 7:00 AM shift, and they did not observe any bruising and the resident did not complain of pain. There was no statement from CNA #5 who according to the 1:1 monitoring log took care of Resident #254 that night as well.<br><br>On 6/26/24 at 10:36 AM, the survey team met with the LNHA, DON, and ADON to discuss their concerns. The ADON confirmed CNA #1, #4, and #6 no longer worked at the facility, and CNA #5 worked the overnight shift and was currently not in the building but there should have been a statement. The ADON continued that the incident either occurred on 8/13/23 or 8/14/23, but no one was certain, but she assessed the resident on 8/14/23. The ADON stated the resident's was unable to ambulate, but attempted to get out of bed or wheelchair. The ADON stated the resident was confused and unable to make their needs known, and the facility determined it was a fall because the resident later stated they fell .<br><br>At that time, the DON acknowledged it should have been looked at how a resident on 1:1 had an unwitnessed fall since staff should be with the resident at all times.<br><br>A review of the facility's undated Abuse Policy included each resident will be free from abuse.residents will be protected from abuse, neglect, and harm while they are residing at the facility .it is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated .the investigation is the process used to try to determine what happened .<br><br>NJAC 4.1(a)(5) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>38080<br><br>NJ Complaint #166562<br><br>Based on interview and review of pertinent facility documents, it was determined that the facility failed to a.) initiate an investigation at the time of an injury of unknown origin was discovered on 8/13/23; and b.) complete a thorough investigation of how a resident on one-to-one (1:1) monitoring by staff had an unwitnessed fall. The deficient practice was identified for 1 of 7 residents reviewed for abuse (Resident #254), and was evidenced by the following:<br><br>A review of the facility's One-to-One Observation policy and procedure dated revised January 2024, included the aim of one-to-one nursing is to provide continuous observation for an individual patient for a period of time during acute physical or mental illness .Primary Physician/Nurse Practitioner shall be notified about the change in patient's condition and order will be obtained for continuous 1:1 observation until further evaluation. Resident/patient's care plan will be initiated and/or updated with resident centered interventions .<br><br>On 6/17/24 at 1:00 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a copy of investigations for reportable events to the New Jersey Department of Health (NJDOH) or any investigations that included injury of unknown origin or allegation of abuse and neglect for July and August 2023.<br><br>The surveyor reviewed an investigation for the closed medical record for Resident #254.<br><br>A review of the Incident Report dated 8/14/23 at 8:30 AM, revealed that the Assistant Director of Nursing (ADON) was called to Resident #254's room to assess the resident who had blue discoloration on both ears, a three centimeter by three centimeter (3 cm x 3 cm) abrasion to right knee; discoloration on right side of face and mid arm. When staff attempted to turn the resident over, they screamed in pain; the physician was made aware and a new order was put into place to send to the emergency room for evaluation. The report indicated no witnesses with additional comments or steps taken to prevent recurrence included resident will be continuously monitored every shift on 1:1. A review of the statement dated 8/14/23 by the Registered Nurse (RN) included they were called to the resident's room and they observed the resident in bed with black and blue marks on right side of face. The resident was confused and unable to say what happened; upon further assessment noted multiple black and blue discoloration on both ears and right side of face. Resident complained of pain when attempted to turn side to side and Supervisor was notified.<br><br>A review of the Emergency Department Discharge Note dated 8/14/23, included the resident had an acute fracture to the transverse process of the lumbar 3 (L3) and lumbar 4 (L4) on left side (lower spine fracture) with no significant abnormalities.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the individual comprehensive care plan (ICCP) included in the investigation, had a focus area dated effective 11/16/22, for behavior related to cognitive impairments; desire to manipulate; chronic mental illness; decline in medical condition; and mood state. Goal included to feel safe in my environment; resident to continue on 1:1 all shifts. A further review included a focus area dated effective 11/16/22, for falls due to medication use with an intervention that included to remain on 1:1 every shift.<br><br>A review of an additional Incident Report included in the investigation packet dated 8/14/23 at 7:00 PM, prepared by the ADON included that they saw the resident on the ground floor, and the ADON asked the resident about their bruise, and the resident stated they fell . The resident did not know when they fell .<br><br>A review of the Progress Notes included a Nursing Note (NN) dated 8/13/23 at 3:06 PM, that on arrival it was noted by the incoming 1:1 staff that the resident had an abrasion on their knee, because the resident was a poor historian, it was unknown how the abrasion got there. Resident alert and oriented to person, denied pain and on assessment no additional injuries noted except abrasion to right knee with no bleeding or discharge noted. This note indicated that the resident's abrasion was discovered on 8/13/23, and not on 8/14/23, as reported on the Incident Report dated 8/14/23 at 8:30 AM.<br><br>On 6/19/24 at 11:05 AM, the surveyor interviewed the Director of Nursing (DON) stated that Resident #254 was on a 1:1 monitoring and should have been monitored at all times so there should not have been an unwitnessed fall. The DON stated that usually the Certified Nursing Aide (CNA) was with the resident, and CNA #1 was looked at. The DON confirmed there were video cameras in the hallways, but could not speak to if the cameras were checked. At that time, the surveyor requested the resident's 1:1 monitoring logs for 8/13/23 and 8/14/23.<br><br>On 6/19/24 at 12:00 PM, the surveyor interviewed the ADON who stated she could not recall if the resident's incident occurred on Sunday (8/13/23) or Monday (8/14/23), but when they were in the building on 8/14/23, they were asked to assess the resident.<br><br>The surveyor continued to review the closed medical record for Resident #254.<br><br>A review of the Resident Face Sheet (admission summary) reflected the resident was admitted to the facility with diagnoses which included schizoeffective disorder, bipolar, and slipping, tripping, and stumbling without fall due to stepping from one level to another.<br><br>A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 5/16/23, reflected the resident usually understood with difficulty communicating some words or finishing thoughts but is able if prompted or given time and sometimes understands by responds adequately to simple, direct communication only. The MDS further reflected the resident transferred between surfaces including to or from bed, chair, wheelchair, standing position with one person physical assist and used a wheelchair.<br><br>On 6/20/24 at 8:59 AM, the surveyor re-interviewed the ADON who stated she thought Resident #254 was placed on a 1:1 monitoring in April of 2023 because they were combative and a fall risk. The ADON stated they were still looking for the resident's 1:1 monitoring log from August 2023, but stated CNA #1 was their aide that day. The ADON stated CNA #1 no longer worked at the facility, and the surveyor requested their phone number.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/20/24 at 10:12 AM, the surveyor asked the DON what the facility's process for investigating was, and the DON stated staff was interviewed and statements were obtained, resident was spoke to, and any additional witnesses. The facility investigated skin tears, injuries of unknown origin, fractures of unknown origin, complaints, verbal, physical, and sexual abuse. The DON stated they gathered statements from staff for 72 hours prior to incident of unknown origin, and the investigation was started immediately. After statements were gathered and the resident was assessed, the statements were reviewed to determined what occurred; if abuse was substantiated; and what interventions could be put into place to prevent the situation from occurring again.<br><br>On 6/20/24 at 11:30 AM, the surveyor requested from the ADON again for CNA #1's phone number.<br><br>On 6/20/24 at 12:17 PM, the surveyor observed CNA #2 and CNA #3 outside of two resident rooms. Both aides confirmed the residents in the rooms were on 1:1 monitoring; and they both confirmed that someone stayed with the resident at all times, and every hour another aide would come to switch with them. They both confirmed the resident was never left alone.<br><br>On 6/20/24 at 1:24 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON, and the surveyor informed them that they were still waiting for the resident's 1:1 monitoring sheets from August 2023. The surveyor also requested additional information regarding why the Progress Notes documented the resident's had a skin abrasion on their right knee on 8/13/24, but it was not investigated until 8/14/24. The surveyor also asked for additional information on how a resident who was on 1:1 monitoring had an unwitnessed fall that resulted in two bruised ears and a fractured back. At that time, the LNHA acknowledged that the investigation should include how the resident on a 1:1 had an unwitnessed fall.<br><br>On 6/26/24 at 9:45 AM, the surveyor reviewed the 1:1 monitoring logs for Resident #254 for 8/13/23 and 8/14/23. The log indicated that CNA #1 was monitoring the resident on 8/13/23 from 7:00 AM through 11:00 PM; CNA #4 and #5 monitored from 8/13/23 at 11:00 PM until 8/14/23 at 7:00 AM; and CNA #6 monitored the resident on 8/14/23 from 7:00 AM until 11 PM. A review of CNA #6's statement from 8/14/23, indicated that at around 8:00 AM on that day, they entered the resident's room to do morning care, and the resident was in bed laying on their back, and the aide noticed black and blue marks on both ears and they called the nurse. CNA #6's statement that they saw the resident at 8:00 AM for care contradicted the 1:1 assignment that indicated CNA #6 was with the resident from 7:00 AM until 11:00 PM on 8/14/23.<br><br>A review of the 8/13/23 11:00 PM to 7:00 AM Certified Nursing Assistant Assignment Schedule reflected that CNA #4 and #5 both had resident assignments that night as well as an assignment of 1:1 with Resident #254.<br><br>A review of CNA #4's statement dated 8/13/23, indicated that they took care of the resident on 8/13/23 during the 11:00 PM to 7:00 AM shift, and they did not observe any bruising and the resident did not complain of pain. There was no statement from CNA #5 who according to the 1:1 monitoring log took care of Resident #254 that night as well.<br><br>On 6/26/24 at 10:36 AM, the survey team met with the LNHA, DON, and ADON to discuss their concerns. The LNHA stated an investigation should have included an assessment of the resident, interviews of possible witnesses and resident, psychology if needed, psychosocial if needed with a social worker, summary, conclusion and interventions put in place so will not happen again, and ICCP was updated.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The ADON confirmed CNA #1, #4, and #6 no longer worked at the facility, and CNA #5 worked the overnight shift and was currently not in the building but there should have been a statement. The ADON continued that the incident either occurred on 8/13/23 or 8/14/23, but no one was certain, but she assessed the resident's on 8/14/23. The ADON acknowledged the CNA discovered the abrasion on 8/13/23, and the investigation should have been started then. The ADON stated the resident's was unable to ambulate, but attempted to get out of bed or wheelchair. The ADON stated the resident was confused and unable to make their needs known, and the facility determined it was a fall because the resident later stated they fell .<br><br>At that time, the DON acknowledged it should have been looked at how a resident on 1:1 had an unwitnessed fall since staff should be with the resident at all times. The DON stated it also should have been looked out where and when the resident fell .<br><br>A review of the facility's undated Abuse Policy included each resident will be free from abuse.residents will be protected from abuse, neglect, and harm while they are residing at the facility .it is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated .the investigation is the process used to try to determine what happened .<br><br>NJAC 8:39-4.1(a)5 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106<br><br>Complaint #: NJ 159451<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) incontinence care was provided for 2 out of 7 residents observed during incontinence rounds (Resident #32 and Resident #147) and b.) nail care was provided during activities of daily living (ADLs) for residents 2 of 4 residents reviewed for ADLs (Resident #60 and Resident #73).<br><br>This deficient practice was evidenced by the following:<br><br>Refer F725<br><br>1. According to the Admission Record (AR), Resident #147 was admitted to the facility with the diagnoses which included but not limited to chronic respiratory failure and tracheostomy (hole in the windpipe to facilitate breathing). The comprehensive Minimum Data Set (MDS), an assessment tool dated 4/10/24, reflected that Resident #147 had moderate cognitive deficits and was dependent on staff for hygiene. Resident #147's individualized comprehensive care plan (ICCP) reflected that the resident required total dependence and one-person physical assistance with personal hygiene.<br><br>According to the AR, Resident #32 was admitted to the facility with the diagnoses which included but not limited to cerebral infarction (stroke). The comprehensive MDS dated [DATE], reflected that Resident #32 had severe cognitive deficits and was dependent on staff for hygiene. Resident #32's ICCP reflected that the staff provided the resident incontinent care every two to four hours, and that the resident required total dependence and one-person physical assistance with personal hygiene.<br><br>On 6/18/24 at 8:02 AM, the surveyor conducted an incontinence tour on the Second Floor nursing unit accompanied by the Unit Manager/Licensed Practical Nurse (UM/LPN #1) and observed the following:<br><br>The surveyor and UM/LPN #1 entered Resident #147's room who was observed lying in bed. UM/LPN #1 asked the resident if she could check their incontinent brief and the resident gave UM/LPN #1 permission. The surveyor observed that the resident's incontinent brief was dry and the chuck (protective bed pad) that was directly under the resident was dry, however the fitted sheet located under the chuck had a large brown/yellow stain that smelled like urine and contained some dry brown stains which UM/LPN #1 identified as bowel movement (bm). UM/LPN #1 was interviewed at this time and stated that the Certified Nursing Assistant (CNA) that was assigned to care for Resident #32 should have changed the resident's sheet when performing incontinence care and should not have left a urine-soaked sheet on the resident's bed. UM/LPN #1 stated that the agency CNA that cared for the resident on the 11:00 PM to 7:00 AM shift must have left the dirty sheet on the resident's bed, because the CNA (CNA #1) that came in this morning just got to the unit and had not made rounds yet. UM/LPN #1 stated that incontinence rounds should be done by the CNA every two hours. The surveyor observed the resident's skin during the tour and the resident's skin was free of skin breakdown.<br><br>On 6/18/24 at 8:45 AM, the surveyor conducted an incontinence tour on the First Floor nursing unit with a Licensed Practical Nurse (LPN #1) and observed the following:<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 9:00 AM, the surveyor accompanied LPN #1 entered Resident #32's room observed the resident lying in bed and the resident was non-verbal. The resident's brief was observed to be very wet with urine and the sheets were observed with a large urine stain that had a strong smell of urine. LPN #1 was interviewed at the time and confirmed that the stain the surveyor observed on the resident's sheet was urine, and that the resident's incontinence brief and the entire bed linen should have been changed. The resident's skin was observed, and the resident's skin was intact and free of breakdown.<br><br>On 6/18/24 at 9:10 AM, the surveyor interviewed UM/LPN #2 for the First Floor nursing unit who stated that the CNA (CNA #2) who was assigned to care for Resident #32 should have made rounds that morning when she had arrived to the unit and checked the residents to see if any residents were incontinent and needed to be changed right away. UM/LPN #2 could not speak to why Resident #32 was wet including the resident's bed linens. She stated that it was import to ensure that residents were clean and dry to protect their skin and to keep the residents comfortable.<br><br>On 6/18/24 at 9:20 AM, the surveyor interviewed CNA #2 who stated that she made rounds that morning and performed an incontinence check for Resident #32. CNA #2 stated that she conducted rounds on Resident #32 in the dark, and did not see the large urine stain on the resident's bed sheets or notice the resident's brief was soaked with urine. CNA #2 stated that the resident's brief and bed linen should have been changed and that it must have been an oversight.<br><br>On 6/19/24 at 9:08 AM, the surveyor interviewed CNA #1 who stated that all incontinent residents should be checked every two hours, and every hour if they urinated more frequently because the resident was on diuretics. CNA #1 stated that it was important to assure that residents' incontinent briefs were changed timely, so that they did not develop breakdown of skin. CNA #2 stated that bed linen should also be changed when the resident wets the bed because leaving urine-soaked bed linen on the bed could also cause odor and skin breakdown, and it was not appropriate to put clean bed linen over wet bed linen. CNA #1 stated that when she arrived on the unit, she made rounds with the CNAs from the previous shift so that she could ensure that all the residents were safe, clean, and dry. CNA #1 stated that breakfast was served at 8:00 AM, so residents should be clean and dry before they start their meals.<br><br>On 6/20/24 at 9:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated that incontinent rounds should be done when staff arrived to the unit to ensure that any priority residents should be taken care of. The DON stated that during shift rounds, the staffs responsibility was to identify soiled residents, change them, and ensure bed linen was changed when soiled; even if a drop of urine got onto the linen, then the linen should be changed. The DON stated that clean linen should not be put on top of dirty linen. The DON stated that all residents should be checked on every two hours to ensure that residents were provided incontinence care timely because residents left soiled were at risk for skin breakdown.<br><br>On 6/26/24 at 10:36 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and survey team acknowledged it was unacceptable to put chuck on a wet and soiled fitted bed sheet. The DON acknowledged it was not appropriate to make care rounds in the dark.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's Bowel and Bladder Incontinence Care policy dated May 2023, included controlling common infections for incontinent residents was part of the overall infection control program .the facility was committed to providing a safe a healthy environment for residents and to minimize or prevent the spread of infections .<br><br>45209<br><br>2. On 6/19/24 at 10:01 AM, the surveyor observed Resident #73 in their room with their fingernails as long and dirty. When asked if their nails have been cleaned or cut by the facility, Resident #73 denied and voiced that they do not like them long and would like them cut.<br><br>On 6/20/24 at 9:25 AM, the surveyor observed Resident #73 the facility's lobby biting on their long and dirty fingernails.<br><br>The surveyor reviewed the medical record for Resident #73.<br><br>A review of the Order Summary Report revealed that Resident #73 was admitted to the facility with diagnosis that included, but not limited to diabetes mellitus, mood disorder, and hypertension (high blood pressure).<br><br>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 5/3/24, reflected a brief interview for mental status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. Section GG (Functional Abilities and Goals) of the MDS identified the resident as requiring Substantial/Maximal Assistance with Personal Hygiene.<br><br>A review of the individualized comprehensive care plan (ICCP) included a focus area dated 10/11/23, for activities of daily living (ADL) Functional/Rehabilitation (Rehab) Potential with interventions that included to have all my needs met.<br><br>On 6/19/24 at 10:20 AM, the surveyor interviewed CNA #2 and #3 who both confirmed that they were responsible for nail care, which included cleaning and filing the nail to a reasonable length.<br><br>On 6/20/24 at 11:23 AM, the surveyor interviewed the Registered Nurse who stated that the CNAs were responsible for assisting in residents' ADLs which included nail care. When asked how resident nails are supposed to appear, the RN responded, clean and short with underneath also clean. The RN further explained that skin checks were completed by the CNA daily and weekly by the nurse during bathing, in which nails were checked for length and appearance.<br><br>On 6/26/24 at 10:35 AM, the LNHA, in the presence of the DON, Regional Nurse, ADON, and survey team acknowledged that it was the expectation of the facility that nail care was completed on the residents.<br><br>2. On 6/17/24 at 10:27 AM, the surveyor observed Resident #60 in their room watching television. The surveyor observed Resident #60's nails were long and dirty. When asked if their nails have been cleaned or cut by the facility, Resident #60 denied and stated they would their nails cut.<br><br>The surveyor reviewed the medical record for Resident #60.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnosis that included, but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder.<br><br>A review of the most recent quarterly MDS dated [DATE], reflected a BIMS score of 12 out of 15, which indicated a moderately impaired cognition.<br><br>A review of the ICCP included a focus area dated 7/13/22, for ADL Functional/Rehab Potential with interventions that included personal hygiene expected with limited assistance of one person physical assist.<br><br>On 6/19/24 at 10:20 AM, the surveyor interviewed CNA #2 and #3 who both confirmed that they were responsible for nail care, which included cleaning and filing the nail to a reasonable length.<br><br>On 6/20/24 at 11:23 AM, the surveyor interviewed the RN who stated that the CNAs were responsible for assisting in residents' ADLs which included nail care. When asked how residents' nails were supposed to appear, the RN responded, clean and short with underneath also being clean. The RN further explained that skin checks were completed by the CNA daily and weekly by the nurse during bathing, in which nails were checked for length and appearance. At that time, Resident #60 approached the nursing station, and the surveyor questioned the length and appearance of the resident's fingernails. Both the RN and UM/LPN #1 confirmed that they were long, dirty, and unacceptable.<br><br>On 6/25/24 at 9:43 AM, the surveyor and DON passed Resident #60 in the hallway. At that time, the DON confirmed that their fingernails were long and dirty, and stated that nail care was an everyday thing and it should have been addressed by the CNAs. The surveyor informed the DON that Resident #60's fingernails were previously addressed with the RN and UM/LPN #1 on 6/20/24, and the DON confirmed that the nail care should have been completed at that time.<br><br>On 6/26/24 at 10:35 AM, the LNHA, in the presence of the DON, ADON, Regional Nurse, and survey team acknowledged that it was the expectation of the facility that nail care was completed on the residents.<br><br>A review of the facility's Resident Care- Grooming policy dated last reviewed January 2023, included .6. Trim the nails using the nail clipper and file to round the tips of the nails. 7. Clean around and under the nails using a moistened cotton swab. Essential Points: the nursing staff will provide observation and care of nails for all residents on bath day as needed .<br><br>A review of the facility's undated Certified Nurse Aide Position document included .5. Bathes the resident in bed, tub or shower, combs hair, cleans and cut fingernails and gives shampoos .22. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and right .<br><br>A review of the facility's undated Licensed Practical Nurse Position document included .9. Supervises and coordinates nursing personnel in providing direct resident care in adherence with state and federal regulations. 10. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and right .<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's undated Registered Nurse Position document included .2. 9. Supervises and coordinates nursing personnel in providing direct resident care in adherence with state and federal regulations.<br><br>A review of the facility's undated Unit Manager/Director Nurse Position document included .4. Assesses the work performance of nursing personnel as it relates to their job description, unit standards of care and goals of the individual 6. Encourages nursing staff to perform their jobs to the fullest of their potential .<br><br>NJAC 8:39-27.2 (g) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080<br><br>NJ Complaint #166769<br><br>Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure a resident who received daily pain management a.) received their pain medications as order and b.) ensure the resident's pain was being assessed and monitored every shift. This deficient practice was identified for 1 of 1 residents reviewed for pain management (Resident #97), and was evidenced by the following:<br><br>On 6/20/24 at 9:23 AM, the surveyor reviewed the closed medical record for Resident #97.<br><br>A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included malignant neoplasm of unspecified site of left and right [male/female] breast (breast cancer); malignant pleural effusion (a condition that occurs when cancer cells cause abnormal amount of fluid to build up between lung and chest cavity); chest pain; and heart failure.<br><br>A review of the individualized comprehensive care plan (ICCP) included a focus area dated 6/14/23 for pain with a goal to be free from pain, and interventions which included assess for signs and symptoms of pain; establish baseline pain through pain assessment. An additional focus are dated 1/7/23, for breast cancer as evidenced by visible lumps/tumors; pain and weight loss with an invasive carcinoma (cancerous tumor) grade two to the right breast and stage 4 that metastasized (spread from one part of the body to another) to the left proximal humerous (upper arm bone); right middle lobe (lung); lytic lesions (bone damage appearing as holes) to bilateral ilia and lumbar vertebrea (upper hip and lower spine) with no interventions exist for this focus.<br><br>A review of the June 2023 Medication Administration Record (MAR) revealed a physician's order (PO) dated 6/21/23, for tramadol 50 milligram (mg) tablet; give one tablet three times a day for pain scheduled at 9:00 AM; 1:00 PM; and 5:00 PM. A review of the corresponding administration times revealed the following:<br><br>On 6/22/24 at 9:00 AM, an indication for not administered see last section<br><br>A review of the corresponding last section indicated on 6/22/23 at 9:00 AM, tramadol not administered and comment not applicable [n/a].<br><br>A review of the corresponding Progress Notes (PN) included a Nursing Note (NN) dated 6/21/23 at 7:53 PM, that the resident was received from the hospital at 4:30 PM, denies pain at this time. The next NN was dated 6/21/23 at 2:42 PM, that included the resident continued on tramadol and was observed in no distress. The note did not include why the resident did not receive their tramadol on 6/22/23 at 9:00 AM.<br><br>A further review on the June 2023 MAR, revealed a PO dated 6/21/23, for pain assessment every shift; use pain scale 0-10. A review of the corresponding pain assessment for 6/22/23 during the 7:00 AM to 3:00 PM shift; reflected the resident was in no pain.<br><br>(continued on next page) |

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| | 315124 | A. Building<br>B. Wing | 06/26/2024 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the July 2023 MAR revealed a PO dated 7/7/23, for tramadol 50 mg tablet; give one tablet by mouth every six hours for pain scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. A review of the corresponding administration times revealed the following:<br><br>On 7/21/23 at 12:00 AM, 6:00 AM, and 12:00 PM, tramadol was not administered and to comment (see last section).<br><br>On 7/27/23 at 6:00 AM, tramadol was not administered.<br><br>A review of the corresponding last section indicated on 7/21/23 at 12:00 AM and 6:00 AM, awaiting medication from pharmacy, and at 12:00 PM, the resident was not in the facility. There was no documentation for the 7/27/23 at 6:00 AM dose.<br><br>A further review of the July 2023 MAR included no PO for pain scale every shift as previously documented in June 2023.<br><br>A review of the Progress Notes for 7/21/23, included a NN at 1:34 PM, that call was placed to the Pharmacy to be made aware of the need for tramadol, and the Pharmacy stated they were awaiting a prescription. The nurse documented they called the Nurse Practitioner (NP) who stated a prescription was sent over the night before, and nurse called Pharmacy to relay information who denied having prescription. The nurse documented they made NP aware. An additional note dated 7/21/23 at 1:37 PM, that resident was out of the facility at 9:05 AM to go to oncology (cancer doctor) with no distress observed. There was no documentation on 7/21/23, that either the physician or NP was made aware the resident did not receive their tramadol for three scheduled administrations or any alternative. There was no documentation of the resident's pain for the missed 12:00 AM and 6:00 AM doses.<br><br>A further review of the Progress Notes did not include any documentation as to why the resident did not receive the tramadol on 7/27/23 at 6:00 AM.<br><br>A review of the comprehensive Minimum Data Set (MDS) dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of a 14 out of 15, which indicated a fully intact cognition. A further review revealed the resident received routine pain medication.<br><br>On 6/20/24 at 9:36 AM, the surveyor interviewed the Director of Nursing (DON) who stated pain was monitored for all residents on the MAR using a pain scale every shift. The DON stated if the resident did not receive their scheduled pain medication, the nurse documented why it was not received. The DON stated the facility had a backup narcotic medication supply, but review of the inventory revealed tramadol was not included. At this time, the surveyor requested the resident's tramadol declining inventory sheets for June and July 2023.<br><br>On 6/20/24 at 1:24 PM, the surveyor informed the DON and Licensed Nursing Home Administrator (LNHA) about the missing doses of tramadol. The surveyor requested any additional information for what was done for those shifts; pain scale; and the resident's June and July 2023 tramadol declining inventory sheets.<br><br>On 6/25/24 at 1:22 PM, the surveyor in the presence of the LNHA, DON, and survey team requested for the third time a copy of the resident's June and July 2023 tramadol declining inventory sheet.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/26/24 at 8:45 AM, the surveyor received the resident's Individual Patient Controlled Substance Administration Record for Tramadol dated first dose administered 7/5/23 at 9:00 AM, and the last dose administered 7/20/23 at 12:00 PM. There were no additional declining inventory sheets.<br><br>On 6/26/24 at 10:35 AM, DON in the presence of the LNHA, Assistant Director of Nursing (ADON), and survey team stated they were unable to locate any additional declining inventory sheets for tramadol. The DON was unable to provide any additional information regarding the missing doses, but confirmed medication should be administered as ordered. The DON acknowledged the facility should have assessed the resident's pain every shift, and if medication was unavailable, the physician was immediately notified and asked if another medication should be given instead. The DON confirmed the resident was on pain medications and it was important to monitor their pain to ensure the medication prescribed was effective.<br><br>At that time, the ADON confirmed the resident had cancer at the time the pain medication was not received.<br><br>A review of the facility's Pain Management policy dated reviewed February 2024, included the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences .reassess patients with pain regularly based on facility's established intervals. If re-assessment findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated .<br><br>NJAC 8:39-27.1(a) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide sufficient nursing staff to ensure residents were provided with care to achieve their highest practical wellbeing by failing to ensure a.) incontinence care was provided for 2 out of 7 residents observed during incontinence rounds (Resident #32 and Resident #147) and b.) medications were administered according to physician's orders for 4 of 4 residents reviewed for medication administration timing (Resident #32, #43, #60, and #250). This deficient practice was evidenced by the following:<br><br>Refer F658 and F677<br><br>1. According to the Admission Record (AR), Resident #147 was admitted to the facility with the diagnoses which included but not limited to chronic respiratory failure and tracheostomy (hole in the windpipe to facilitate breathing). The most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 4/10/24, reflected that Resident #147 had moderate cognitive deficits and was dependent on staff for hygiene. Resident #147's individualized comprehensive care plan (ICCP) reflected that the resident required total dependence and one-person physical assistance with personal hygiene.<br><br>According to the AR, Resident #32 was admitted to the facility with the diagnoses which included but not limited to cerebral infarction (stroke). The most recent comprehensive MDS dated [DATE], reflected that Resident #32 had severe cognitive deficits and was dependent on staff for hygiene. Resident #32's ICCP reflected that the staff provided incontinent care every two to four hours and that the resident required total dependence and one-person physical assistance with personal hygiene.<br><br>On 6/18/24 at 8:02 AM, the surveyor conducted an incontinence tour on the Second Floor nursing unit accompanied by the Unit Manager/Licensed Practical Nurse (Um/LPN #1) and observed the following:<br><br>The surveyor and UM/LPN #1 entered Resident #147's room who was observed lying in bed. UM/LPN #1 asked the resident if she could check their incontinent brief and the resident gave UM/LPN #1 permission. The surveyor observed that the resident's incontinent brief was dry and the chuck (protective bed pad) that was directly under the resident was dry, however the fitted sheet located under the chuck had a large brown/yellow stain that smelled like urine and contained some dry brown stains which UM/LPN #1 identified as bowel movement (bm). UM/LPN #1 was interviewed at that time, and stated that the Certified Nursing Aide (CNA) that was assigned to care for Resident #32 should have changed the resident's sheet when performing incontinence care and should not have left a urine-soaked sheet on the resident's bed. UM/LPN #1 stated that the Agency CNA that cared for the resident on 11:00 PM to 7:00 AM shift must have left the dirty sheet on the resident's bed because the CNA (CNA #1) that came in that morning just got to the unit and had not made rounds yet. UM/LPN #1 stated that incontinence rounds were completed by the CNA every two hours. The surveyor observed the resident's skin during the tour and the resident's skin was free of skin breakdown.<br><br>A review of the CNA Assignment sheet for 6/18/24, revealed that for the resident census of 47, there were five assigned CNAs. CNA #1 had thirteen assigned residents to care for.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/18/24 at 8:45 AM, the surveyor conducted an incontinence tour on the First Floor nursing unit with a Licensed Practical Nurse (LPN) and observed the following:<br><br>On 6/18/24 at 9:00 AM, the surveyor accompanied the LPN into Resident #32's room observed the resident lying in bed and was non-verbal. The resident's incontinence brief was observed to be very wet with urine and the sheets were observed with a large urine stain that had a strong smell of urine. The LPN was interviewed at the time and confirmed that the stain the surveyor observed on the resident's sheet was urine and that the resident's incontinence brief should have been changed and the entire bed linen should have been changed. The resident's skin was observed, and the resident's skin was intact and free of breakdown.<br><br>On 6/18/24 at 9:10 AM, the surveyor interviewed UM/LPN #2 for the First Floor nursing unit who stated that CNA #2 who was assigned to care for Resident #32 should have made rounds that morning when she had arrived at the unit and checked the residents to see if any residents were incontinent and needed to be changed right away. UM/LPN #2 could not speak to why Resident #32 was wet including the resident's bed linens. UM/LPN #2 stated it was import to assure that the residents were clean and dry to protect the resident's skin and to keep residents comfortable.<br><br>A review of the CNA Assignment sheet for 6/18/24, revealed that for the resident census of 50, there were five assigned CNAs. CNA #2 had eleven assigned residents to care for.<br><br>On 6/18/24 at 9:20 AM, the surveyor interviewed the CNA #2 who stated that she made rounds that morning and performed an incontinence check for Resident #32. CNA #2 stated that she did not see the large urine stain on the resident's bed sheets and did not notice that the resident's incontinence brief was soaked with urine because she did not turn the light on in the resident's room. CNA #2 stated that the resident's incontinence brief and bed linen should have been changed and that it must have been an oversight.<br><br>On 6/19/24 at 9:08 AM, the surveyor interviewed CNA #1 who stated that all incontinent residents should be checked every two hours, and if a resident urinated more frequently because the resident was on diuretics, that they should be checked every hour. CNA #1 stated that it was important to assure that residents' incontinent briefs were changed timely so that they did not develop breakdown of skin, as well as bed linen should be changed when the resident wets the bed. CNA #1 explained that leaving urine-soaked bed linen on the bed could also cause odor and skin breakdown, and it would not be appropriate to put clean bed linen over wet bed linen. CNA #1 stated that when she arrived on the unit, she made rounds with the CNAs from the previous shift so that she could ensure that all the residents were safe, clean, and dry. CNA #1 stated that breakfast was served at 8:00 AM, so residents should have been clean and dry before they started their meals.<br><br>On 6/20/24 at 9:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated that incontinence rounds should be done when staff arrived at the unit to ensure that any priority residents should be taken care of. The DON stated that during shift rounds, the staffs responsibility was to identify soiled residents and to ensure that the residents were changed and bed linen were changed when soiled, emphasizing that even if a drop of urine got onto the linen, then the linen should be changed. The DON stated that clean linen should not be put on top of dirty linen, and all residents should be checked on every two hours. The DON explained that it was important to assure that residents were provided incontinence care timely and that residents left soiled were at risk for skin breakdown.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/25/24 at 10:13 AM, the surveyor interviewed the Staffing Coordinator in the presence of the Licensed Nursing Home Administrator (LNHA), who stated she scheduled nursing staff in accordance with State regulation which required one CNA to every eight residents for the morning shift; one CNA for every ten residents for the evening shift; and one CNA to every fourteen residents for the overnight shift. The Staffing Coordinator stated it was very hard to find staff; that the facility did not always meet the required ratios.<br><br>On 6/26/24 at 10:36 AM, the LNHA in the presence of the DON, Assistant Director of Nursing (ADON), and survey team acknowledged it was unacceptable to put chuck on a wet and soiled fitted bed sheet. The DON acknowledged it was not appropriate to make care rounds in the dark.<br><br>38080<br><br>2. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that the facility relied heavily on Agency staffing. At that time, the surveyor requested the Nurse Staffing Report to be completed for the weeks of 11/6/22 to 11/19/22.<br><br>On 6/18/24 at 11:56 AM, the LNHA informed the surveyor that the facility did not have the staffing records for 2022; that they were trying to get the information from the payroll company. The surveyor asked the LNHA if the facility needed to maintain staffing records, and the LNHA confirmed the facility should have the records.<br><br>On 6/25/24 at 10:13 AM, the surveyor reviewed the Nurse Staffing Report sheets completed by the facility for 11/6/22 through 11/19/22 which revealed the following:<br><br>On 11/6/22, there was a census of 91 residents with a total of four nurses throughout the twenty-four hour period.<br><br>On 11/7/22, there was a census of 91 residents with a total of two nurses throughout the twenty-four hour period with no nurses on the overnight.<br><br>On 11/8/22, there was a census of 91 residents with a total of four nurses throughout the twenty-four hour period.<br><br>On 11/9/22, there was a census of 93 residents with a total of three nurses throughout the twenty-four hour period with no nurses on the overnight.<br><br>On 11/10/22, there was a census of 93 residents with a total of four residents throughout the twenty-four hour period.<br><br>On 11/11/22, there was a census of 92 residents with a total of four nurses throughout the twenty-four hour period.<br><br>On 11/12/22, there was a census of 93 residents with a total of three nurses throughout the twenty-four hour period.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/13/22, there was a census of 93 residents with a total of two nurses throughout the twenty-four hour period with no nurses on the evening shift.<br><br>On 11/14/22, there was a census of 94 residents with a total of two nurses throughout the twenty-four hour period with no nurses on the overnight shift.<br><br>On 11/15/22, there was a census of 95 residents with a total of three nurses throughout the twenty-four hour period.<br><br>On 11/16/22, there was a census of 95 residents with a total of three nurses throughout the twenty-four hour period with no nurses on the evening shift.<br><br>On 11/17/22, there was a census of 93 residents with a total of two nurse throughout the twenty-four hour period with no nurse on the evening shift.<br><br>On 11/18/22, there was a census of 94 residents with a total of one nurse throughout the twenty-four hour period with no nurses on the day or evening shifts.<br><br>On 11/19/22, there was a census of 93 residents with a total of one nurse throughout the twenty-four hour period with no nurse on the day or evening shifts.<br><br>At that time, the LNHA stated that the facility could not locate the November 2022 staffing sheets, and they used payroll documents to complete the staffing report. The LNHA stated the facility relied heavily on Agency staff who were not included in those reports.<br><br>On 6/25/24 at 10:17 AM, the surveyor interviewed the Staffing Coordinator in the presence of the LNHA who stated she was not here at the time, and could not locate the staffing sheets for that time. The Staffing Coordinator stated she could reach out to the Agencies to determine the staff provided.<br><br>On 6/25/24 at 10:21 AM, the surveyor interviewed the DON in the presence of the LNHA and Staffing Coordinator who acknowledged the staffing sheets needed to be maintained and kept as a reference at all times. The DON stated the unit managers kept records of the assignment sheets, but the sheets cannot be located. The DON acknowledged her role was to oversee the nursing department, and confirmed the staffing levels were not acceptable.<br><br>At that time, the surveyor requested the Medication Administration Record with the times medication was administered for five sampled residents (Resident #32, #43, #60, #250, and #252) for the time period of 11/6/22 through 11/19/22.<br><br>On 6/25/24 at 12:30 PM, the LNHA provided the surveyor with Administration Documentation Audit Detail Report (ADADR) for the weeks of 11/1/22 to 11/13/22 for Resident #32, #43, and #250. The LNHA stated Resident #252 was discharged from the facility in July of 2022, and Resident #43 was out of the facility at the time so she provided the week of 11/25/24.<br><br>On 6/25/24 at 1:30 PM, the surveyor interviewed the DON who stated medication should be administered as ordered; the right person, medication, dose, route, and time. The DON continued medication was to be administered at the time prescribed or one hour before or after the medication was timed for.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The surveyor reviewed the ADADR reports provided which revealed the following:<br><br>For the weeks of 11/1/22 through 11/13/22:<br><br>For Resident #32, their medications were administered out of the time parameters: for the 8:00 AM dose on 11/2/22, 11/3/22, 11/4/22, 11/5/22, 11/6/22, 11/7/22, 11/10/22, 11/11/22, 11/12/22, and 11/13/22; for the 9:00 AM doses on 11/4/22, 11/5/22, 11/11/22, and 11/12/22; for the 12:00 PM doses on 11/2/22, 11/3/22, 11/4/22, 11/8/22, 11/10/22, and 11/11/22; for the 5:00 PM doses on 11/2/22, 11/3/22, 11/4/22, and 11/11/22; for the 6:00 PM dose on 11/2/22; and the 10 PM dose on 11/11/22. It was documented the residents tube feeding (nutrition administered through a surgical tube into the stomach) scheduled at 4:00 PM, was administered late on 11/3/22, 11/7/22, 11/8/22, 11/9/22, 11/11/22, and 11/12/22. It was also documented on 11/4/22, that their 8:00 AM medications were administered at 2:04 PM; and their 11/11/22 8:00 AM and 9:00 AM medications were administered at 1:26 PM.<br><br>For Resident #60, their medications were administered out of the time parameters: for the 8:00 AM doses on 11/1/22; 11/2/22; 11/3/22; 11/4/22; 11/5/22; 11/6/22; 11/7/22, 11/9/22, 11/11/22, 11/12/22, and 11/13/22; for the 9:00 AM doses on 11/1/22, 11/4/22, 11/5/22, and 11/12/22 for the 1:00 PM doses on 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/7/22, 11/8/22, and 11/11/22; for the 5:00 PM doses on 11/2/22, 11/3/22, 11/4/22, 11/7/22, 11/11/22, and 11/12/22; and the 9:00 PM doses on 11/2/22, 11/11/22, 11/12/22, and 11/13/22. It was documented that they received their 11/4/22 9:00 AM medications at 2:18 PM.<br><br>For Resident #250, their medications were administered out of the time parameters: for the 8:00 AM dose on 11/11/22; for the 9:00 AM doses on 11/3/22, 11/8/22, 11/9/22, 11/11/22, 11/12/22, and 11/13/22; for the 1:00 PM doses on 11/9/22, 11/10/22, and 11/13/22; and the 5:00 PM doses on 11/3/22, 11/4/22, 11/5/22, and 11/8/22. It was documented the resident's 9:00 AM doses on 11/3/22 were administered at 1:52 PM, and their 5:00 PM doses on 11/5/22 were administered at 10:26 PM.<br><br>For the week of 11/25/22 through 11/30/22, Resident #43's medications were administered out of the time parameters: for the 9:00 AM dose on 11/29/22; the 5:00 PM dose on 11/27/22; and the 6:00 PM dose on 11/27/22. It was documented the 9:00 AM medications were administered at 12:06 PM on 11/29/22.<br><br>On 6/26/24 at 10:30 AM, the LNHA provided additional staffing for the weeks of 11/6/22 through 11/19/22, which revealed on 11/6/22, there were three nurses for the day shift and one for the overnight; on 11/7/22, there were two nurses for the day and overnight shifts and three for the evening; on 11/8/22 there were three nurses for the evening and two nurses for the overnight shifts; on 11/9/22 four nurses for the day shift, two for the evening and one for the overnight shifts; on 11/10/22 there was four for the day, three for the evening, and two for the overnight shift; for 11/11/22 there was four for the day, three for the evening, and one for the overnight shift; on 11/12/22 there were two nurses for the day four for the evening, and two for the overnight; for 11/13/22 there was three for the day, two for the evening, and one for the overnight; for 11/14/22 there was two for the evening and one for the overnight; for 11/15/22 and 11/16/22 there was two for the evening and overnight; 11/17/22 there were three for the evening and two for the overnight; for 11/18/22 there were three for the evening and one for the overnight; and for 11/19/22 there were two for the evening and one for the overnight.<br><br>On 6/26/24 at 10:34 AM, the LNHA acknowledged these concerns.<br><br>(continued on next page) |

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|---|---|---|---|
| | 315124 | A. Building<br>B. Wing | 06/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Belle Care Nursing and Rehabilitation Center | 439 Bellevue Avenue<br>Trenton, NJ 08618 |

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

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's Bowel and Bladder Incontinence Care policy dated May 2023, included that controlling common infections for incontinent residents was part of the overall infection control program .the facility was committed to providing a safe a healthy environment for residents and to minimize or prevent the spread of infections .<br><br>A review of the facility's Nursing and Sufficient Staff policy dated last reviewed July 2023, included it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment .the facility will supply sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans .<br><br>NJAC 8:39-25.2 (a); 27.1(a) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>48964<br><br>Complaint NJ #163249; 168809<br><br>Based on observation, interview, review of the medical record, and other pertinent facility documents, it was determined that the facility failed to maintain an accurate, complete, and easily accessible medical record. This deficient practice was identified for 3 of 35 residents' medical records reviewed (Resident #97, #248, and #252), and was evidenced by the following:<br><br>1. On 6/17/24 at 1:00 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) a copy of the investigation for the reportable event to the New Jersey Department of Health (NJDOH) for Resident #248 reported on 4/3/23.<br><br>On 6/18/24, the surveyor was provided with a copy of the form submitted to the NJDOH, but was not provided with the investigation. The surveyor requested a copy of the investigation.<br><br>A review of the investigation reported to the NJDOH included an Investigation Summary dated 4/3/23, that Resident #248 on 4/3/23 at approximately 1:00 PM was observed by the nurse to be lethargic sitting in their wheelchair. The nurse immediately performed a sternal rub (rubbing the knuckles on the breastbone) and the resident immediately responded physically and verbally. The report did not include any statements or assessments.<br><br>On 6/19/24 at 1:25 PM, the surveyor asked for a third time to provide the investigation for the incident that occurred with Resident #248.<br><br>On 6/20/24 at 10:12 AM, the surveyor interviewed the Director of Nursing (DON) regarding the investigation process who stated interviews were obtained from staff, residents, and any witnesses; the resident was assessed; and then based on the information gathered, the facility determined what happened and put interventions in place to prevent the incident from reoccurring.<br><br>On 6/20/24 at 1:16 PM, the surveyor requested for the fourth time the investigation for the facility reported event. The DON stated regarding the investigation, accident/incident reports, and/or witness statements, We have them but can't find it.<br><br>On 6/25/24 at 1:28 PM, the surveyor interviewed the LNHA who confirmed medical records should be easily accessible, complete, and accurate. The LNHA confirmed all medical records that the survey team had requested should be easily accessible, accurate, and maintained.<br><br>On 6/26/24 at 10:36 AM, the LNHA in the presence of the DON, Assistant Director of Nursing (ADON), and survey team stated the facility was unable to locate the investigation for Resident #248. The LNHA confirmed the investigation should have included an assessment of the resident; interview of possible witnesses and resident; psychological evaluation if needed; psychosocial if needed with a social worker; summary, conclusion, and interventions put in place so incident would not occur again which was updated in the care plan.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 38080<br><br>2. According to the Resident Face Sheet (an admission summary) Resident #252 was admitted to the facility in 2022 with diagnoses kidney failure. The face sheet did not include the resident's discharge date .<br><br>A review of the electronic Admissions Record revealed Resident #252 was discharged from the facility in July of 2022.<br><br>On 6/19/24 at 12:09 PM, the surveyor interviewed the Medical Records personnel who stated after a resident was discharged from the facility, the facility maintained the medical records for ten years.<br><br>On 6/25/24 at 10:33 AM, the surveyor requested for the LNHA a copy of Resident #252's discharge summary. The LNHA stated that at the time of the resident's stay in the facility, the facility utilized paper medical charts and needed to locate the record from medical records.<br><br>On 6/25/24 at 1:28 PM, the surveyor requested again from the LNHA a copy of Resident #252's discharge summary. At that time, the LNHA confirmed medical records should be easily accessible, complete, and accurate. The LNHA confirmed all medical records that the survey team had requested should be easily accessible, accurate, and maintained.<br><br>On 6/26/24 at 10:14 AM, the LNHA informed the surveyor that there was no discharge summary for the resident. The LNHA stated that staff informed her that one was completed, but the facility was unable to locate it. The surveyor asked why and where the resident was discharged to, and the LNHA was unable to speak to it stating the facility did not have electronic medical records at the time.<br><br>On 6/26/24 10:35 AM, the ADON in the presence of the LNHA, DON, and survey team stated Resident #252 was transferred to another facility, and the discharge summary should have been completed, but cannot be located.<br><br>3. On 6/20/24 at 9:23 AM, the surveyor reviewed the closed medical record for Resident #97.<br><br>A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included malignant neoplasm of unspecified site of left and right [male/female] breast (breast cancer); malignant pleural effusion (a condition that occurs when cancer cells cause abnormal amount of fluid to build up between lung and chest cavity); chest pain; and heart failure.<br><br>A review of the June 2023 Medication Administration Record (MAR) revealed a physician's order (PO) dated 6/21/23, for tramadol 50 milligram (mg) tablet; give one tablet three times a day for pain scheduled at 9:00 AM; 1:00 PM; and 5:00 PM. A review of the corresponding administration times revealed the following:<br><br>On 6/22/24 at 9:00 AM, an indication for not administered see last section<br><br>A review of the corresponding last section indicated on 6/22/23 at 9:00 AM, tramadol not administered and comment not applicable [n/a].<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the corresponding Progress Notes (PN) included a Nursing Note (NN) dated 6/21/23 at 7:53 PM, that the resident was received from the hospital at 4:30 PM, denies pain at this time. The next NN was dated 6/21/23 at 2:42 PM, that included the resident continued on tramadol and was observed in no distress. The note did not include why the resident did not receive their tramadol on 6/22/23 at 9:00 AM.<br><br>A review of the July 2023 MAR revealed a PO dated 7/7/23, for tramadol 50 mg tablet; give one tablet by mouth every six hours for pain scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. A review of the corresponding administration times revealed the following:<br><br>On 7/21/23 at 12:00 AM, 6:00 AM, and 12:00 PM, tramadol was not administered and to comment (see last section).<br><br>On 7/27/23 at 6:00 AM, tramadol was not administered.<br><br>A review of the corresponding last section indicated on 7/21/23 at 12:00 AM and 6:00 AM, awaiting medication from pharmacy, and at 12:00 PM, the resident was not in the facility. There was no documentation for the 7/27/23 at 6:00 AM dose.<br><br>On 6/20/24 at 9:36 AM, the surveyor interviewed the DON who stated the facility had a backup narcotic medication supply, but review of the inventory revealed tramadol was not included. At this time, the surveyor requested the resident's tramadol declining inventory sheets for June and July 2023.<br><br>On 6/20/24 at 1:24 PM, the surveyor informed the DON and LNHA about the missing doses of tramadol, and requested the resident's June and July 2023 tramadol declining inventory sheets.<br><br>On 6/25/24 at 1:22 PM, the surveyor in the presence of the LNHA, DON, and survey team requested for the third time a copy of the resident's June and July 2023 tramadol declining inventory sheet.<br><br>On 6/26/24 at 8:45 AM, the surveyor received the resident's Individual Patient Controlled Substance Administration Record for Tramadol dated first dose administered 7/5/23 at 9:00 AM, and the last dose administered 7/20/23 at 12:00 PM. There were no additional declining inventory sheets.<br><br>On 6/26/24 at 10:35 AM, DON in the presence of the LNHA, ADON, and survey team stated they were unable to locate any additional declining inventory sheets for tramadol.<br><br>A review of the facility provided Medical Record Policy dated last revised 5/1/24, included Purpose: To ensure that each resident's medical record is maintained in accordance with accepted professional standards and practices .<br><br>NJAC 8:39-35.2(k) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209<br><br>Complaint NJ #159451; 159539; 159783; 162168<br><br>Based on observation, interview, and review of other facility documentation it was determined that the facility failed to maintain resident environment, equipment, and living areas in a safe, sanitary, and homelike manner. This deficient practice was identified for 2 of 2 nursing units (First and Second Floor) and was evidenced by the following:<br><br>On 6/19/24 at 9:09 AM, the surveyor observed in the hallway by Resident room [ROOM NUMBER] a wheelchair with brown matter that resembled fecal matter, smeared across the seat cushion and down the leg of the wheelchair onto the wheels.<br><br>On 6/20/24 at 10:52 AM, the surveyor observed on the Second Floor nursing unit a strong urine odor while approaching Resident room [ROOM NUMBER]. The surveyor entered the room to discover the floor by Bed B was wet and sticky. In addition, puddles of wetness was observed on the bed.<br><br>On 6/20/24 at 11:41 AM, the surveyor requested that Registered Nurse (RN #1) walk with them to Resident room [ROOM NUMBER]. While approaching the room, RN #1 acknowledged the strong urine odor, and confirmed that they were aware of the room's condition.<br><br>On 6/20/24 at 11:55 AM, the Unit Manager/Licensed Practical Nurse (UM/LPN #1) confirmed the strong smell of urine and acknowledged that Resident room [ROOM NUMBER] should not be in that condition.<br><br>On 6/25/24 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON) who acknowledged that Resident room [ROOM NUMBER] should have been cleaned in a timely fashion; that residents should receive quality of care and living environments.<br><br>On 6/26/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Assistant Director of Nursing (ADON), and survey team acknowledged that the wheelchair and resident room, which resulted in the urine smell in the hallway, were not acceptable.<br><br>A review of the facility's undated Quality of Life- Homelike Environment policy included .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order .e. Pleasant, neutral scents .<br><br>A review of the facility's Cleaning and Disinfecting Wheelchairs, [Reclining Chairs, Bedside Commode, & Privacy Curtains policy dated last reviewed March 2024, included . 1. Ensure that wheelchairs and [reclining chairs] are kept clean and in good repair [ .] 4. Designate an area for cleaning wheelchairs, [reclining chairs], and bedside commode. If necessary, use a power spray and clean heavily soiled wheelchairs outside .<br><br>NJAC 8:39-4.1 (a), 11 |