STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaris Health at Kearny	206 Bergen Ave Kearny, NJ 07032

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, interviews, and facility policy review, the facility failed to ensure the call light was within reach for one of one resident (Resident (R) 69) out of a sample of 26 residents reviewed for accommodation of needs and preferences. This failure had the potential to cause R69 to have unmet care needs. Findings include: Review of R69's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R69 was admitted to the facility on [DATE] with diagnoses which included heart failure, osteoarthritis, age related osteoporosis without current pathological fracture, and history of falls. Review of R69's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/23/24, located under the RAI (Resident Assessment Instrument) tab, showed a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating severe cognitive impairment. R69 was assessed to have no upper or lower extremity impairment and required partial/moderate assistance to go from lying to sitting on side of bed. Review of R69's Monthly Nursing Summary, dated 09/03/24 and located under the Assessments tab of the EMR, revealed documentation the resident was alert and oriented to person, place, and time and was able to verbalize needs to staff and follow instructions. Review of R69's Physician Orders, located in the EMR under the Orders tab, revealed a physician order, dated 07/25/24 for, Call bell within reach every shift. Review of R69's Care Plan, located in the EMR under the Care Plan tab and last revised 07/26/24, revealed R69 was at risk for falls related to multiple falls in the community. Interventions included to be sure call light was within reach and encourage to use it for assistance as needed. During an observation and interview on 09/24/24 at 12:29 PM, R69 was observed seated in her room in her wheelchair. Her call light was on her bed approximately four feet behind her and out of reach. R69 stated that she wanted to get back into her bed, but she did not know where her call light was. During an observation and interview on 09/25/24 at 8:42 AM, the call light was observed tied to the bedside rail, hanging down the side of the bed, out of sight, and out of reach of the resident. R69 stated she did not know where her call light was. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/27/24 at 8:45 AM, R69 was observed resting in bed. The resident's call light was observed on the right side of the bed, on the floor. R69 said she did not know where her call light was. During an interview on 09/27/24 at 8:46 AM, Licensed Practical Nurse (LPN) 1 entered R69's room for medication administration. LPN1 stated that residents' call lights should be placed near their laps or within reach. Upon observation of R69's call light on the floor, she confirmed that it was improperly placed and out of reach of the resident. LPN1 said she would place it back within reach of R69. LPN1 stated that all staff were responsible for ensuring call lights were accessible. During an interview on 09/27/24 at 8:48 AM, Registered Nurse (RN) 1 confirmed that all staff were responsible for ensuring call lights were in reach of the residents. Upon entering R69's room, LPN1 informed RN1 that she had picked the call light up off the floor and placed it within reach of the resident. RN1 stated that all staff should ensure call lights were accessible to residents. NJAC 8:39-4.1(A)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 28604 Based on interview, record review, and policy review, the facility failed to honor residents' choices to have their food warmed by staff members daily for 99 of 107 residents that received meals in the facility. This failure resulted in the residents' choices being denied. Findings include: During a group meeting of 19 alert and oriented residents on 09/26/24 at 2:01 PM, the residents stated they had concerns related to staff not being allowed to heat food up for them if they wanted something heated up after 7:00 PM. The residents stated that in the past, the nurse aides could take food to the breakroom and heat it up for the residents, but they could no longer do that. The residents stated they had been told it was facility policy that foods could not be heated up for them after 7:00 PM because dietary staff were no longer present at the facility. During an interview on 09/27/24 at 3:22 PM, Certified Nursing Aide (CNA) 4 confirmed she was not allowed to heat up food for residents and residents could not have their food warmed up after 7:00 PM daily. During an interview on 09/27/24 at 3:27 PM, the Administrator confirmed dietary staff were the only staff trained and allowed to reheat food for the residents, and residents, family members and nursing staff were not allowed to reheat food. The Administrator acknowledged the kitchen hours were from 5:30 AM to 7:00 PM daily, so residents could have their food warmed up during those hours. The Administrator also stated that only allowing the kitchen staff to reheat food for the residents was to prevent unsafe temperatures of the food. During an interview on 09/27/24 at 3:51 PM, the Regional Dietician and Assistant Director for Hospitality verified that dietary staff were allowed and trained to reheat the resident's food in the facility. The Regional Dietician stated the dietary staff were trained to prevent food borne illnesses while other staff, residents, and families were not trained. During an interview on 09/27/24 at 4:22 PM, Resident (R) 8 stated residents had until 7:00 PM to ask the kitchen staff to warm their food as they were the only staff allowed to do it. During an interview on 09/27/24 at 4:32 PM, CNA3 indicated the kitchen staff heated up food for residents during hours of operation. CNA3 also indicated nursing staff were not allowed to heat up food for residents. During an interview on 09/27/24 at 4:38 PM, R49 indicated he had asked the nursing staff to heat up his food after 7:00 PM and was told the kitchen staff had to do it when they were open. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated policy titled, Resident Rights, provided by the facility, revealed, Purpose: To ensure all facility staff (including employees, consultants, contractors, volunteers, and other caregivers who provide care and services to residents on behalf of the facility) observe and respect residents' right. Policy: All facility staff shall observe resident rights. Facility staff will recognize and respect residents right to make individual choices. Facility staff will educate and provide risk vs [versus] benefits if applicable . Review of the facility's policy titled Food Reheating, dated 01/24/24 and provided by the facility, revealed, Policy: To ensure the safe reheating of food for residents, this policy outlines the procedure for reheating meals. Procedure: Only dietary staff are permitted to reheat food for residents to the appropriate temperature at their request. Reheating services are available from 5:00 AM to 7:00 PM daily by the dietary department. A list of available food, snacks, and beverages will be provided and served by the nursing department during off hours. NJAC 8:39-4.1(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46319 Based on record review and staff interviews, the facility failed to develop a comprehensive care plan directing measurable goals and interventions related to the use of an anticoagulant for one of five resident (Resident (R) 105) reviewed for unnecessary medications out of a total sample of 26. This failure placed the resident at risk for unmet care needs and the inability to monitor for signs and symptoms of abnormal bleeding. Findings include: Review of R105's Comprehensive Care Plan, located in the electronic medical record (EMR) under the Care Plan tab, revealed R105 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation. Review of R105's Medication Administration Record (MAR), dated 09/2024 and located under the Orders tab of the EMR, revealed R105 received apixaban, (an anticoagulant used in the treatment of atrial fibrillation) five milligrams (mg) twice daily. Review of R105's Comprehensive Care Plan, did not show a focus, measurable goals, or interventions for the use of the anticoagulant medication. During an interview with the Director of Nurses (DON) on 09/27/24 at 3:45 PM, the DON stated that a resident receiving any type of blood thinner such as an anticoagulant or antiplatelet should be care planned for monitoring of abnormal bleeding by the clinical staff. Review of the facility's policy titled, Interdisciplinary Plan of Care Policy, revealed, . This facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths and goals . A comprehensive person-centered care plan for each resident shall be developed and implemented that includes measurable objectives and timeframes to meet a resident's medical, nursing . needs . NJAC 8:39-11.2 NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observation, interview, and record review, the facility failed to provide assistance with showering for one of three residents (Resident (R) 14) reviewed for activities of daily living (ADLs) out of a total sample of 26. This failure increased the potential for R14 to have unmet hygiene needs. Findings include: Review of the facility's policy titled, Shower Sheets, approved 02/14/24, revealed, To ensure accurate documentation of resident showers. This policy applies to all nursing staff providing shower assistance with showers. After assisting with or observing a resident's shower, staff will complete the Shower Sheet for that day. The following information must be included: Date of the shower . Observations of the resident's skin condition . Residents will be offered showers on their assigned days. If a resident requests a shower on a non-shower day, it will be accommodated. If a resident refuses a shower, this must be noted on the Shower Sheet . Review of the facility's policy titled, ADL [activities of daily living] Documentation Flow Sheet, last revised 07/16/24, revealed, The ADL performance level will be documented daily utilizing the ADL documentation flow sheet in the Point of Care (POC) kiosks. The flow sheet will reflect the ADL performance of a resident in a 24 hour period including . Bathing/Showering . The flow sheet is to be completed by the CNA (certified nursing assistant) assigned . The flow sheet identifies three shifts: 7-3, 3-11, and 11-7 for each ADL tasks . The Nurse Aide will document the resident's performance in each specific ADL before the end of the shift worked. At the end of the week, all sheets will be reviewed for completeness . Review of R14's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R14 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, unspecified convulsions, cellulitis of abdominal wall, and cystostomy status. Review of R14's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/24 and located under the MDS tab of the EMR, revealed R14 had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated R14 had moderate cognitive impairment. It was recorded R14 required substantial/maximal assistance for showering, with helper doing more than half the effort. R14 was recorded to have an indwelling urinary catheter and was always incontinent of bowel. The resident was documented to not reject care. Review of R14's Care Plan, located in the EMR under the Care Plan tab, dated 07/20/23, revealed R14 had an ADL self-care performance deficit related to medical diagnoses of cerebrovascular accident and seizure disorder, and required total assistance with most ADLS. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction. Review of R14's Care Plan, located in the EMR, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R14's Weekly Shower and Skin Assessment sheets, provided by the facility, documented: -08/01/24 Shower given -08/05/24 Shower -08/08/24 Refused -08/12/24 Refused shower, bed bath given -08/15/24 Refused -08/19/24 Refused, shower cap given -08/22/24 Shower -08/26/24 Refused -08/29/24 Refused shower, bed bath given -09/02/24 Refused shower -09/05/24 Refused shower -09/09/24 Pt (patient) refused -09/12/24 Pt refused -09/16/24 Pt declined -09/19/24 Refused shower -09/23/24 Shower Review of August 2024 and September 2024 revealed 16 opportunities for showering, on R14's scheduled Monday and Thursday shower days. Out of 16 opportunities, the resident received four showers, two bed baths, one shampoo shower cap, and nine refusals. There was no documentation that indicated the resident was reoffered showers again after a refusal. Record review of R14's Progress Notes, under the Progress Notes tab of the EMR, revealed no nursing documentation of the resident refusing showers or bed baths. Progress Notes also failed to document that the resident stated no regularly when asked questions. Record review of R14's Point of Care (kiosks) under the Task tab of the EMR and dated 08/27/24 through 09/27/24, revealed under Bathing and shower every Monday and Thursday 7-3 shift, there was no documentation of Bathing: Self Performance (how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower for the 30 day look back period. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R14's Point of Care (kiosks) under the Task tab of the EMR and dated 08/27/24 through 09/27/24, revealed under Bathing and shower every Monday and Thursday 7-3 shift, there was no documentation of Bathing: Support Provided (how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower for the 30 day look back period. Record review of R14's Point of Care (kiosks) under the Task tab and dated 08/27/24 through 09/27/24, revealed under Bed Bath, there was no documentation of Bathing: Self Performance (how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower for the 30 day look back period. Record review of R14's Point of Care (kiosks) under the Task tab and dated 08/27/24 through 09/27/24, revealed under Bed Bath, there was no documentation of Bathing: Support Provided (how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower for the 30 day look back period. During an observation and interview on 09/24/24 at 2:10 PM, R14 was observed in her room and in her bed. Her hair was noted to be greasy, combed back, and numerous dandruff flakes were observed on the top of her head. She stated that she did not choose when she had her showers and could not recall how often she was getting them or when she had her last one. Shower sheet documentation revealed that the resident had received a shower on 09/23/24. During an observation and interview on 09/25/24 at 11:33 AM, R14 was observed in her room watching television from her wheelchair. Her hair was again observed to be greasy, slicked back, and with visible dandruff flakes on the top of her head. When asked if she had received a recent shower, she shook her head and said no. During an observation and interview on 09/26/24 at 1:30 PM, the Director of Nursing (DON) and Certified Nursing Assistant (CNA) 2 entered R14's room and asked the resident if she had been showered recently. R14 shook her head no. The resident's hair was again observed to be greasy, slicked back, and dandruff flakes were observed on the top of her head. The DON and CNA2 said that R14 had been getting her showers. During an interview on 09/26/24 at 2:40 PM, CNA2 stated that she used a shampoo shower cap on R14 on the non-shower days. She said that when she combed out R14's hair she continued to have flakes even after shampooing her hair. CNA2 said that R14 would answer no when asked questions on a regular basis, even if care had been provided. During an interview on 09/27/24 at 8:54 AM, the DON said that the facility was going to purchase a new shampoo for R14 to help with dandruff, instead of what they were currently using on her hair. The DON said that R14 habitually said no to things, even when she was receiving showers. During a follow-up interview on 09/27/24 at 10:35 AM, CNA2 said that R14 seldom refused showers. She stated that she wrote down the showers that were given on the shower sheets and in the computer kiosk. She said that she would document on the days the resident received a shower, but not when a bed bath was given. CNA2 stated that if a resident refused a shower, she would let the nurse know so they could document in the resident's record. She confirmed R14 was scheduled to receive showers on Monday and Thursdays, and if the resident refused a shower, she would not ask again until their next scheduled shower day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/27/24 at 10:42 AM, CNA1 said that aides used shower sheets to document showers given on scheduled days. She said if the resident refused a shower, the aide would go back and try again later. If the resident continued to say no, they would tell the nurse. CNA1 said that the aides would also chart showers in the kiosk system. During an interview on 09/27/24 at 6:10 PM, Registered Nurse (RN) 1 said that if a resident refused a shower, the CNAs would document the refusal on the shower sheets and then tell the nurse. RN1 said that the nurse would then document the refusal in a progress note, and then contact the family. She said that the CNA would next offer a shower on the next scheduled shower day. NJAC8:39-4.1(a) NJAC 8:39-27.2

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on interview, record review, and facility policy review, the facility failed to ensure one of one resident (Resident (R) 51) reviewed for dialysis out of a total sample of 26 was offered a snack and/or fluids on dialysis days when away from the facility during mealtimes and failed to accurately document the resident's nutritional intake. This had the potential to cause hypoglycemic incidents and provided inaccurate data for the resident's nutritional assessments. Findings include: Review of the facility's policy titled, Dialysis, dated 05/11/10, revealed, . The nurse admitting the resident will verify the center/clinic, the schedule and transportation arrangement made for the resident. If no transportation arrangement has been made, the nurse will then call and make the transportation arrangement from the resident. The dietary department will be notified of the resident's admission. Type of diet ordered and provided resident with a brown bag (snack) if applicable, on days of dialysis schedule, if Dialysis Center permits. It will be noted on the dietary slip that will be submitted to the dietary department on the day of admission . Review of R51's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R51 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, diabetes mellitus, metabolic encephalopathy, and anemia. Review of R51's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/15/24 and located under the MDS tab of the EMR, revealed R51 had a Brief Interview for Mental Status (BIMS) score of thirteen out of 15, which indicated R51 was cognitively intact. It was recorded that the resident received dialysis while a resident at the facility. Review of R51's Care Plan, located in the EMR under the Care Plan tab and dated 07/12/24, revealed R51 needed hemodialysis related to renal failure. Interventions included to encourage the resident to go for the scheduled dialysis appointments. Pick up time was 9:30 AM and chair time was 10:30 AM on Tuesdays, Thursdays, and Saturdays. The Care Plan intervention identified a hemodialysis center location that was no longer used after a physician order change on 08/23/24. Review of R51's Care Plan, located in the EMR under the Care Plan tab, last revised 09/23/24, revealed R51 was at nutritional risk related to . end stage renal disease on hemodialysis . Interventions included to encourage intake by mouth and to maintain communication with the hemodialysis center related to nutritional plan of care. Review of R51's EMR under the Orders tab revealed an order, dated 08/23/24, for the resident to go to dialysis on Tuesday, Thursday, Saturday at 11:00 AM at a different location than identified in the 07/12/24 care plan. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/24/24 at 3:36 PM, R51 said she went to dialysis three times a week. She said she leaves the facility at 9:00 AM and gets back about this time (3:36 PM). She stated she had just returned from dialysis and that the facility did not send her with any food. She said she used to go out with food on dialysis days, with a sandwich and juice. R51 showed a bag with some saltines inside and stated that her sister would sometimes bring her the crackers so she would have something to eat. She confirmed that she ate breakfast at approximately 8:00 AM, and then did not eat again until she returned from dialysis. She stated she was starving. At this time, Registered Nurse (RN) 1 brought a food tray to the resident and said she had reheated her lunch tray. R51 said that this was a problem, because she now had lunch brought to her so late, they would be bringing dinner soon, too. During an interview on 09/26/24 at 9:15 AM, R51 said she was preparing to go out to dialysis but had run out of the crackers her sister had provided. During an interview on 09/26/24 at 9:30 AM, RN1 said that it was her understanding that the resident was not sent out to dialysis with anything to eat or snack on because of infection control concerns. During a subsequent interview on 09/26/24 at 9:40 AM, RN1 said that the facility would be sending the resident with a snack since she is complaining of being hungry when she is gone. RN1 confirmed that because the resident was also diabetic, she could get hypoglycemic. During an interview on 09/26/24 at 10:50 AM, the Director of Nursing (DON) said that she believed the resident was not supposed to take anything to eat or drink because the dialysis center was concerned about infection control during the procedure. She stated she was not sure if this was identified in a dialysis contract or if there was any documented communication with the dialysis center stating this to the facility staff. On 09/26/24, the DON provided a document titled, Patient's Acknowledgement of Risks for Eating and Drinking Hot Liquids on Dialysis. This form recorded, . strongly recommends that I do not eat food or drink hot liquids while I am on the dialysis machine . The form was signed on 10/02/23, prior to the admission to the facility, or to the new dialysis location ordered on 08/23/24. During an interview on 09/27/24 at 10:35 AM, Certified Nursing Assistant (CNA) 2 said that when a resident ate their meals, the aides documented the meal percentages in the Point of Care (POC) kiosk system. She said she worked during the breakfast and lunch meal service, and she would capture the intake percentages at the end of her shift. Record review of R51's Point of Care (kiosks) under the Task tab for Eating Percentage, documented that the resident had eaten her lunch on 09/24/24 at 1:47 PM, when the resident was not present at the facility. Meal intake in the 30 day look back period regularly documented the resident meal intakes for breakfast and lunch at similar times, when the resident was at dialysis or revealed a delay in meal intake of six to eight hours. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 09/27/24 at 11:37 AM, the current dialysis center that R51 attended was contacted. The facility director stated that the resident would not be allowed to eat while on the dialysis system, but residents were not prevented from bringing or eating a drink and snack prior or after the procedure. She stated that it would be important to provide these items, especially if they were diabetic and had to manage their blood sugar. She said residents often brought these items because they were on the side of humanity. During an interview on 09/27/24 at 6:10 PM, RN1 said that the CNAs should capture meal intakes within an hour or two after meals were served, or at the end of the day when their shifts were over. She stated that the aides knew their residents, so they could remember how much they ate during the multiple meal services and document it accurately in the kiosk system. NJAC 8:39-17.1, 17.2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315192	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46319 Based on record review, staff interview, and policy review, the facility failed to ensure staff followed physician ordered parameters for blood pressure (BP) medications for one of five residents (Resident (R) 105) reviewed for unnecessary medications. R105 received antihypertensive medications when the systolic blood pressure (SBP) was below the parameters set by the attending physician. This had the potential to cause hypotensive episodes for the resident. Findings include: Review of R105's Comprehensive Care Plan, located under the Care Plan tab of the electronic medical record (EMR), revealed R105 was admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure). Review of R105's Medication Administration Record (MAR), located under the Orders tab of the EMR and dated 09/18/24, revealed R105 was to receive Entresto Oral Tablet (a cardiac medication used to treat hypertension), 24-26 milligrams (mg) and metoprolol tartrate (a cardiac medication used to treat hypertension) oral tablet 25 mg three times daily. Instructions were to hold both medications if R105's SBP was below 110. Further review of R105's MAR revealed: 09/18/24 at 5:00 PM - BP was 101/72, 09/19/24 at 5:00 PM - BP was 106/66, 09/20/24 at 5:00 PM - BP was 105/63, and 09/21/24 at 5:00 PM - BP was 105/63. It was recorded R105 received both the Entresto and metoprolol at these times even though the SPB was below the physician ordered parameter of 110. On 09/27/24 at 4:10 PM, Registered Nurse (RN) 3, who administered R105's medications on the above referenced dates and times, stated, I'm aware of the SBP parameters and do not give either of the antihypertensive medications if the SBP is below 110. RN3 confirmed the MAR recorded the medications were administered on the above referenced dates and times. She stated, Yes. It shows that I gave the medication but I'm sure that I didn't give it. RN3 was asked if there was documentation the medications were held. She stated, No, it shows I gave the meds. Review of the facility's policy titled, Medication Administration, revised 01/20/24, revealed, . Medications shall be administered in a safe and timely manner, and as prescribed. 7. The following information must be check/verified for each resident prior to administering Medications . Vital signs, if necessary . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, interviews, and facility policy review, the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment for one of 26residents (Resident (R) 63) whose beds were observed for bed rail safety out of a total sample of 26. The facility failed to ensure R63's bed rails were identified and repaired timely when broken, which had the potential to cause injury to the resident. Findings include: Review of the facility's policy titled, Side Rail Policy, last reviewed 07/23/24, revealed, The purpose of these guidelines is to ensure the safe use of side rails . Side rails may be appropriate when used to assist with mobility and transfer and to maintain safety related to the resident's medical condition . When side rail usage is appropriate, the facility maintenance department will ensure that side rails are secure and in proper working order. Review of R63's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R63 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis lumbosacral region and encephalopathy. Review of R63's Physician Orders, located in the EMR under the Order tab, revealed a physician order on 10/10/22 for, May have two half side rails while in bed every shift. Review of R63's Care Plan, located in the EMR under the Care Plan tab and dated 04/12/23, revealed R63 had bilateral half side rails on the bed due to difficulty repositioning in bed to relieve pressure, secondary to muscle weakness and decreased balance/trunk control. Interventions included that the resident and staff were educated on the safe use of bilateral half-sided bedrails to assist in repositioning self in bed without the risk of entrapment and use as an enabler, to obtain a physician order, and to review side rails quarterly. Record review of R63's Quarterly Side Rail Assessment, dated 08/22/24, revealed that side rails were indicated at the present time to use as an enabler to enhance mobility and promote independence. Review of R63's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/23/24 and located under the RAI (Resident Assessment Instrument) tab, showed a Brief Interview for Mental Status (BIMS) score of thirteen out of 15, indicating no cognitive impairment. R63 was assessed to have upper and lower extremity impairment on one side and required partial/moderate assistance to roll left and right and to go from lying to sitting on side of bed. During an observation on 09/24/24 at 12:34 PM, R63's half bed rails were observed in place on both sides of the resident's bed. The left bed rail was observed to be loose and easy to shake back and forth. There was an approximate six-inch gap between the bed rail and the mattress. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 09/25/24 at 12:30 PM, the left bed rail on R63's bed was again noted to be wobbly and tilted outwards approximately six inches away from the bed frame. During an interview on 09/26/24 at 9:15 AM, Registered Nurse (RN) 1 said that nurses would do an initial assessment if they believed a resident would benefit from positioning bed rails, and then therapy would look at the resident. She said that nurses would monitor the bed rails on the Treatment Administration Record (TAR) and check to ensure the bed rails were in place. RN1 confirmed that maintenance would be responsible for ensuring the bed rails were placed and maintained properly. During an observation and interview on 09/26/24 at 9:30 AM, the Director of Nursing (DON) confirmed that nurses would determine if they thought a resident might benefit from bed rails, and then therapy would do an assessment. The DON said that the nurses on the floor were responsible for ensuring the bed rails were present on resident beds, but they did not monitor bed rail condition or placement. Upon observing R63's left bed rail, she confirmed it was loose and tilted outwards approximately six inches away from the bed. She said that maintenance would fix the bed rail, and she would be educating staff to ensure that they not only documented that the bed rails were in place on resident beds, but also that they were in safe working condition. During an interview on 09/27/24 at 8:54 AM, RN1 said that nursing staff had a communication book at the nurse station where they could write down repair needs for the maintenance department. Upon review, she confirmed that R63's bed rail had not been identified as needing repair. During an interview on 09/27/24 at 9:40 AM, the Regional Maintenance Director stated that nurses used a written log at the nurse station to let maintenance know of needed repairs. He said that the nurses did not always document things that needed to be fixed. He confirmed that the process was not very effective in showing what work had been completed and that the maintenance department needed to do a better job of reviewing bed rails to make sure they were not broken and in need of repair. NJAC 8:39-27.1(a)