| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315195 | A. Building<br>B. Wing | 07/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Autumn Lake Healthcare at Berkeley Heights | 35 Cottage Street<br>Berkeley Heights, NJ 07922 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Reasonably accommodate the needs and preferences of each resident.<br><br>39399<br><br>Based on observation, interview and document review it was determined that the facility failed to ensure an adequate supply of linens (sheets, pillowcases, towels, bed linens, wash cloths, bed pads and gowns) were provided to accommodate the number of residents who resided in the facility to meet their needs and maintain the dignity and well-being of all residents for 4 of 4 resident units.<br><br>Reference N.J.A.C. 8:39 - 21.3:<br><br>(a) The facility shall have a supply of linen appropriate to the resident's needs that is clean, in good repair, and is at least three times the number of residents.<br><br>(b) The facility shall have a supply of blankets that is at least two times the number of residents.<br><br>The deficient practice was evidenced by the following:<br><br>During the Entrance Conference on 7/14/24 at 7:46 PM, the facility's Director of Nursing (DON) confirmed to the surveyor that the facility's census as of 7/14/24 was 97 residents.<br><br>On 7/15/24 at 10:56 AM, it was reported to the surveyor that the facility does not have enough towels according to the resident's feedback.<br><br>A review of the form titled, Resident Council Meeting Minutes dated 3/27/24 revealed that it was discussed during the meeting when the resident's felt there were not enough towels on the unit for them.<br><br>On 7/17/24 at 12:40 PM, the surveyor toured the facility's laundry room with the Housekeeping Director (HD) who was employed at the facility for one year. The HD stated that there was enough supply of linens for the residents.<br><br>On 7/17/24 at 2:15 PM, the HD provided a copy of a form titled, Linen Delivery Schedule. The HD stated to the surveyor that the form showed the number of linens that were distributed to each of the resident's units. Each resident's unit will be provided 1 linen cart every 7-3 shift. 3-11 shift and 11-7 shifts that included 45 sheets (flat), 45 sheets, 15 pillowcases, 35 towels, 25 wash cloths, 30 gowns, 45 pads and 25 blankets. During the 11-7 shift, each linen cart will be provided with the same number of linens above except for blanket which was 15 blankets.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | The surveyor requested a facility policy for linen regarding process and distribution.<br><br>The facility did not provide any policy regarding Linen process and distribution.<br><br>On 7/18/24 at 12:44 PM, the surveyor informed the Licensed Nursing Home Administrator and the DON regarding the above concerns. No additional information was provided.<br><br>N.J.A.C 8:39-21.3(a)(b) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193<br><br>Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to follow their Abuse, Neglect and Exploitation Policy and Procedure, to protect residents from physical abuse and staff by failing to ensure: a.) Resident #37 was spoken to in a harsh and abusive manner which resulted in Resident #37 crying on 07/15/24, in the presence of the surveyor and b.) Resident #50 was protected from physical abuse by Resident #74, who had a history of wandering. On 01/24/2024, Resident #74 wandered into Resident #50's room and Resident # 74 physically assaulted Resident #50 by punching them in the mouth and knocking out their front tooth. This deficient practice was identified for 2 of 3 resident's (Resident #50 and #37) reviewed for abuse, and was evidenced by the following:<br><br>1. On 07/15/24 at 12:29 PM, during the lunch meal, the surveyor observed Resident #37 in the main dining room. Resident #37 had two plates of pureed food in front of them on the table. One plate had a white scoop of pureed food with gravy, one was a beige scoop of pureed food with no gravy, and one was a green scoop of pureed food. The other plate had beige particles mixed into the white scoop of pureed food and did not have gravy and a green scoop of pureed food.<br><br>On that same date and time, the surveyor interviewed Resident #37 who stated that the food was too salty and there was no gravy and the resident did not want to eat the food. The surveyor asked the resident what was for lunch and the resident stated, I have no idea.<br><br>On that same date and time, an Activity Staff (AS) member approached Resident #37 and the surveyor. At that same time, a Dietary Staff (DS) member quickly approached Resident #37 and in a loud and harsh voice stated, what do you want? We go through this everyday. You can't eat regular food, you know that. Resident #37 began to cry and while Resident #37 was crying the DS asked Resident #37 what they wanted. The AS then stated to the DS, Resident #37 was saying the food was salty.<br><br>On 07/15/24 at 12:55 PM, the surveyor interviewed the AS regarding the witnessed interaction between the DS and Resident #37. The AS stated, that the DS had a tone of voice with Resident #37 and that you cannot speak to residents in that manner. The AS confirmed that Resident #37 did not like the food and that the DS did not ask the resident what they wanted. The AS stated that the DS' behavior was not new and she has heard the DS speak in this tone of voice with other residents in the dining room in the past.<br><br>On 07/15/24 at 1:58 PM, the surveyor met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) and asked if they had been made aware of anything that transpired today during the lunch meal in the dining room. They replied, No. The surveyor then informed the DON and LNHA of the above observation. The DON stated, I would expect to hear about it immediately .it is cruel, and the LNHA stated, we will take care of it right away. The DON stated, that is abuse, this will be more than an investigation, it will be discipline.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A review of Resident #37's electronic medical record revealed a Psychotropic Monthly/Quarterly Summary dated 07/03/24, which revealed the resident was able to express their needs but often hallucinates scenarios, and shows increased anxiety at times and will begin to scream and cry. Reported that resident made a comment or suicidal ideation in the past but has not made such comments since. Resident is often smiling and waging at staff, residents and visitors. Gets along well with roommate. Enjoys participation in activities .<br><br>Review of Resident #37's Care Plan revealed: A Focus area, revised on 10/06/2023, for impaired cognitive function or impaired thought processes r/t [result to] Disease Process/Intellectual disability. Friendly and can make needs known. Interventions included: . Face resident when speaking, make eye contact . The resident understands consistent, simple directive sentences. Provide with necessary cues . Revised on 08/30/2019.<br><br>2. On 07/14/24 at 6:30 PM, during the initial tour of the facility, the surveyor observed Resident #50 in bed. A strong urine odor was noted in the room. The resident informed the surveyor another resident had been wandering in their room the previous night and urinated in their trash can. Resident #50 identified the other resident as Resident #74 who lived across the hall.<br><br>On 07/15/24 at 10:30 AM, the surveyor observed Resident #50 in bed, Resident #50 informed the surveyor that Resident #74 punched them in the mouth a couple months ago. Resident #50 informed the surveyor that Resident #74 came to the room and attempted to reach for something on their bedside table. When Resident #50 intervened and tried to stop Resident #74 from touching their things, Resident #74 became angry and punched Resident #50 in their mouth knocking out their front tooth.<br><br>On 07/16/24 at 10:30 AM, the surveyor reviewed Resident #50's electronic medical record.<br><br>The Admission Face sheet (An Admission Summary) reflected that Resident #50 was admitted to the facility with diagnoses which included but were not limited to; acute respiratory failure, depression and anxiety.<br><br>Review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 01/27/24, reflected that Resident #50 scored a 15 out of 15, on the Brief Interview for Mental Status (BIMS), which indicated that the resident had intact cognition.<br><br>Review of the Quarterly MDS dated [DATE], reflected a BIMS score of 14 out of 15, which indicated that the resident had intact cognition.<br><br>A review of Resident #50's initial Care Plan dated 03/16/23 last revised 03/27/24, indicated that Resident #50 had self-limiting physical mobility related to neurological deficits, weakness. Resident #50 had no care plan in place for being accusatory toward staff or any residents.<br><br>Further review of Resident #50's Care Plans revealed a focus area for teeth are in various stages of disrepair initiated on 01/26/24. The care plan goal was for Resident #50 not to have difficulty eating or drinking through the next review date. Target date: 07/24/2024. Care plan Interventions included: dental referrals dated 01/26/24. Encourage good oral hygiene.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A review of the Nurse's Progress notes, signed by the Licensed Practical Nurse Unit Manager (LPN/UM) and dated 01/24/24 timed 13:29 [1:29 PM] revealed the following: Was called to the room by the immediate nurse stating that [Resident #50] wanted to speak with someone. Upon entering room with the licensed Social Worker (LSW), [Resident #50] stated during the night another resident, [Resident #74] came to their room and began to go through their things. When [Resident #50] told [Resident #74] to stop, [Resident #74] hit [Resident #50] in the mouth causing their tooth to come out. Scant blood was noted on the bed sheet. Teeth noted to be in various stages of disrepair, front tooth noted to be missing but no obvious bruising or injury was noted in or around the mouth. Head to toe evaluation, no injuries noted. Resident #50 stated that they did not have any pain. Resident #50 stated that they were not fearful .<br><br>A review of the Nurse's Progress notes dated 01/24/24 and timed 14:47 PM [2:47 PM] from the physician indicated the following: Received page alerted the on call physician that [Resident #50] was assaulted by a resident who wandered into their room. [Resident #50] was allegedly hit in the mouth and lost a tooth. Patient, has no open wounds, and in no distress at this time. Advised close monitoring to area.<br><br>A subsequent review of Resident #50's Care Plan revealed that the Care Plan was not updated to reflect the physical altercation/incident of 1/24/24, between Resident #50 and Resident #74 and interventions were not put into place to prevent Resident # 74 from continuing to enter their room.<br><br>A review of the Reportable Event Record/Report dated 1/25/24 timed at 2:30 PM, provided by the Director of Nursing (DON), revealed that Resident #50 reported that the incident occurred on 1/24/24 at 2:30 AM. The Certified Nursing Assistants (CNAs) who worked the 11:00 PM- 7:00 AM shift were asked about the incident and could not confirm that they observed Resident #74 wandering into Resident #50's room during the night. Further review of the Reportable Event Record/Report indicated that 1:1 supervision immediately implemented for Resident #74.<br><br>Review of the Reportable Event Record/Report Conclusion revealed that the night shift staff were questioned and did not see Resident #74 entering Resident #50's room. Further investigation was conducted including camera surveillance which indicated that at no time throughout the course of the night was [Resident #74] seen going in or out of any residents room.<br><br>On 07/17/24 at 9:38 AM, the surveyor conducted a follow up interview with Resident #50 regarding the incident dated 01/24/24. Resident #50 stated that during the night of 1/25/24, Resident #74 entered their room and attempted to reach for something on their bedside table. They attempted to stop Resident #74, then Resident #74 hit them in their mouth and knocked out their front tooth. Resident #50 stated they reported the incident to the staff in the morning.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the Psychiatrist Nurse Practitioner notes dated 01/25/2024 timed 20:57 [8:57 PM] revealed, Patient seen and evaluated for blow to the face. Father at bedside. Patient reports someone entered their room around 2:30 AM on Wednesday and was rummaging through their belongings. When the patient confronted the other resident, the other resident punched them in the mouth and left the room. Of note, per nursing staff, camera surveillance does not show evidence of another person entering the room at that time. [Resident #50] reports their front tooth fell out and they swallowed the tooth. Noted some bleeding that stopped after a short period of time. Denies loss of consciousness or other injuries. Patient reports some tenderness of the upper lip but denies issues with eating or breathing. Denies headaches or vision changes, but does endorse some decreased hearing of his left ear which has developed recently but before this incident. Patient is not concerned about his losing his tooth. Patient's primary concern is their chronic back pain .Patient has no evidence of fracture or lacerations of the jaw or rest of the face/body. Noted front tooth is missing with no signs of infection or bleeding. Overall poor dentition. Patient to be evaluated by dentist. Ice can be applied to the upper lip to reduce inflammation.<br><br>3. The surveyor reviewed the medical record for Resident # 74.<br><br>A review of Resident #74's Face Sheet reflected that Resident #74 was admitted to the facility and had diagnoses which included but were not limited to; vascular dementia, major depressive disorder, cerebral infarction. and generalized anxiety disorder.<br><br>A review of the most recent Quarterly Minimum Data Set (MDS), dated [DATE], reflected that Resident # 74 had a BIMS score of 00 out of 15, which indicated the resident's cognition was severely impaired. A further review of the resident's MDS, Section E - Behavior indicated the resident had no behaviors.<br><br>A review of Resident #74's Care Plan revised on 09/19/23, reflected a focus area that Resident #74 had impaired cognition related to Dementia. The goals of the Care Plan was for Resident #74 would improve current level of cognition through the review date of 06/06/24. Care plan Interventions included; to communicate with resident and family regarding Resident capabilities and needs, keep routine consistent and try to provide consistent care givers, monitor and document any change in cognitive function.<br><br>Further review of the Care Plans revealed a focus area for antidepressant medication and [Resident #74] wanders in and out of rooms at night. The Interventions revised on 01/26/24, indicated to redirect when the resident wanders, especially at night and monitor at regular intervals through the night.<br><br>Further review of the Care Plans revealed a focus area for elopement risk/wanderer. [Resident #74] wanders aimlessly throughout the unit. Dated initiated 02/27/2024. The goal was for [Resident #74] not to leave the facility unattended through the review date. Target Date 06/06/2024. Care Plan Interventions included: to Distract [Resident #74] from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Wander alert to left ankle. The care plan did not address Resident #74 from continuing to wander into other resident's rooms, rummaging and taking their belongings. Resident #74's Care Plan was not updated to reflect the incident of 01/24/24.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | A review of the Nurses Progress Notes written by the 3:00 PM - 11:00 PM shift Licensed Practical Nurse (LPN ) dated 12/03/2023 timed 18:22 [6:22 PM], indicated, Continuously pacing up and down the hallways to point of exhaustion, taking anything and everything on their way, very difficult to redirect.<br><br>Review of a Behavioral Note dated 12/03/2023 timed 18: 23 [6:23 PM ] revealed, that the resident was Pacing up and down the hallways going into other residents room taking their belongings, difficult to redirect.<br><br>Review of the Nurse's Progress Notes dated 01/05/24, revealed: [Resident #74] slept on and of short interval, needs constant redirection to go back to their room at all times.<br><br>Review of a Behavioral Note dated 1/25/24 timed 7:21 AM, revealed: [Resident #74] alert with confusion. Continent and ambulatory. Monitored closely, 30 minutes watch, to ensure their safety and the safety of others. [Resident #74] went to the hallway once and was redirected. At 4:35 AM, [Resident #74] went into Room A 31's bathroom and was redirected by this writer into their bathroom. Left in their bed at 7:00 AM.<br><br>A review of the Nurses Progress Notes dated 01/26/24 timed 16:20[4:23 PM], indicated the following: [Resident #74] continued on 30 minutes check, resident noted trying to wander, but able to redirect back to their room or sitting in common area watching television.<br><br>Further review of Nurses Progress Notes written by a Registered Nurse (RN) on 02/29/24 at 13:55 PM [1:35 PM], reflected that a CNA observed Resident #74 on the floor in room [ROOM NUMBER]. [Resident #74] reported right hip and rib pain. The facility did not indicate how Resident #74 was able to wander into another resident's room and staff was not aware. The progress noted indicated that Resident #74 was placed on two (2) hours monitoring. The facility did not investigate further to rule out abuse.<br><br>Review of the Nurse's Progress Notes dated 03/15/24 timed 14:54 [2:54 PM], from the Social Worker (SW) revealed the following: SW advised [Resident #74's] Representative (RR) that Resident #74 had been physically well, but continued to go into other residents's rooms and take their things. The Interdisciplinary Team felt that the facility was not an appropriate placement for Resident #74.<br><br>Review of the Nurses Progress Notes dated 03/15/24 timed 16:19 [4:19 PM] revealed, More anxious this shift. Resident very agitated, going into other residents room and in their personal belongings. Resident more difficult to redirect.<br><br>Review of the Behavioral Note dated 03/25/24 timed 00:56 AM, documented by an LPN indicated, Continues to wander into other residents rooms, touching their belongings, eat their food and urinate in hampers.<br><br>Review of the Nurses Progress Notes dated 03/27/24 timed 07:28 AM, documented by an LPN indicated, [Resident #74] continues to wander into other resident's room and taking their stuffs, eat their food and urinate in their rooms. [Resident #74] is very difficult to redirect. [Resident #74] starting on 2 hours monitoring. Resident likes to pacing up and down the unit.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Review of the Behavioral Note dated 03/31/24 timed 07:26 AM, documented by an LPN revealed, Slept for 1 hour, going into other residents room ate their snacks.<br><br>Review of the Nurses Progress Notes dated 04/29/24 at 07:33 AM, revealed, [Resident #74] kept going into room [ROOM NUMBER] B, took their snacks, needs redirection.<br><br>Review of the Nurses Progress Notes dated 04/30/24 timed 23:39 [11:39 PM] revealed, CNA stated, [Resident #74], pulled on red stop sign from Room A 33 and fell backwards holding on to sign.<br><br>Review of the Nurses Progress Notes dated 06/24/24 at 7:37 AM, revealed, [Resident #74] stayed in their room slept on and off, turned off their roommate's Bipap (type of noninvasive ventilation that helps residents breathe, machine that delivers air through a mask on their face.) I have to turn on the Bipap machine more than 3 times throughout the night. 7-3 nurse made aware to monitor [Resident #74] and the roommate.<br><br>Review of the Psychiatry Progress notes dated 02/22/24, revealed that [Resident #74's] sleep had improved.<br><br>Further review of the Psychiatry Progress notes dated 5/16/24, revealed, As per reports [Resident #74] has had continued difficulty sleeping at night, attempting to enter other resident's rooms. Trazodone (anti-depressant commonly used off-label to treat insomnia) 100 mg at bedtime for insomnia.<br><br>On 07/17/24 at 09:42 AM, the surveyor observed Resident #74 wandering into room [ROOM NUMBER]. The CNA escorted Resident #74 out of the room into the hallway.<br><br>On 07/17/24 at 10:05 AM, the surveyor interviewed the CNA who stated that Resident #74 always wandered into other residents' rooms and needed to be redirected continuously.<br><br>On 07/18/24 at 10:30 AM, the surveyor observed Resident #74 entering room [ROOM NUMBER] on the North Wing. An Activity Aide (AA) who happened to be in the hallway, went to the room and escorted Resident #74 out of the room. The AA revealed that she observed the behavior of wandering into other resident's room every day since she is been here.<br><br>On 07/18/24 at 11:15 AM, the surveyor interviewed the AA who stated that Resident #74 wandered continuously in other resident rooms and was very difficult to redirect. The AA also stated that all staff were aware of the behavior.<br><br>On 07/18/24 at 11:20 AM, the surveyor conducted an interview with CNA#1 who stated that she had a good rapport with Resident #74. CNA#1 stated that Resident #74 wandered constantly, could be difficult to redirect and their behavior could change suddenly. The surveyor asked about her knowledge of the incident/altercation between Resident #74 and #50, the CNA responded, I was told of the incident by another staff, I do not work the 11:00 -PM -7:00 AM shift.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 07/18/24 at 11:30 AM, the surveyor interviewed the LPN/UM who revealed that she learned of the incident when she reported to work that morning and confirmed that she assessed Resident #50 and entered the note in the medical record. The LPN/UM also stated that she did not believe the incident had occurred as Resident #50 wanted their father to take them home. She confirmed that Resident #74 had a behavior of wandering into other residents rooms and taking other residents belongings. She informed the surveyor that Resident #74 had a prior behavior of going into room [ROOM NUMBER] and urinating in the room. The LPN/UM was not aware that the behavior was still present. The surveyor reviewed Resident #74's Care Plan with the UM and she confirmed that the behavior was not addressed on the care plan. The UM stated that the behavior was triggered and documented in the progress notes and should have been addressed in the care plan.<br><br>On 07/18/24 at 12:15 PM, the surveyor interviewed the Nurse Practitioner (NP) in the presence of the LPN/UM and another surveyor. The NP stated that Resident #74 had displayed the behavior of wandering and urinating in other residents rooms since December 2023. The NP further stated, that Resident #74 was pleasantly confused. The surveyor asked how was she made aware of the resident behaviors. The NP stated, that staff and other residents reported Resident #74 being up all nights, going into their belongings, urinating in their trash can as of December 2023. The NP further stated that Resident #74 does not sleep at night, has vascular dementia and their medications had been reviewed several times to improve sleep. The NP further stated that Resident #74 was not malicious, but just very confused.<br><br>On 07/18/24 at 12:30 PM, the surveyor interviewed the Activity Director (AD) who stated that Resident #74 would participate at times in activities. Review of the activity attendance book revealed most of the days were marked as sleeping. Resident #74 would be asleep during the day and could not participate in activity. The surveyor asked if she knew if Resident #74 had ever hit another resident and the AD stated, Yes. She had heard that Resident #74 wandered to another resident's room and tried to take their snacks. When the other resident attempted to stop them, Resident #74 reportedly got angry and assaulted Resident #50. The AD added that Resident #50 was provided with a wheelchair recently and staff was to escort Resident # 50 to activity during the day.<br><br>A review of the facility's Abuse, Neglect and Exploitation policy last revised 7/12/23, included:<br><br>It is the facility policy of this facility to provided protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.<br><br>Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Mental Abuse included, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Verbal Abuse, means the use of oral, written or gestured communication or sounds that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.<br><br>Physical Abuse includes but is not limited to hitting, slapping, punching, biting and kicking.<br><br>III. Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves;<br><br>B. Identifying, correcting and intervening in situation in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents and assure that staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.<br><br>On 07/19/24 at 2:30 PM, during the pre-exit conference with the Regional Nurse, the DON and the Assistant Director of Nursing the above observations and concerns were discussed.<br><br>N.J.A.C. 8:39- 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 - Many | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>Complaint # NJ 159516<br><br>48422<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure their policy for Abuse Investigation and Icidents and Accidents was followed to ensure a thorough investigation was completed, and documented for: a.) an allegation of verbal abuse by staff to Resident #60, and b.) for a resident who was found on the floor, facing upright with a folded jacket under head, was saturated with urine, difficult to arouse and required emergent transport via 911 to the hospital (Resident #295). This deficient practice occurred for 1 of 1 resident investigated for verbal abuse (Resident #60), 1 of 3 residents investigated for unplanned hospitalization (Resident #295) and was evidenced by the following:<br><br>a) On 7/14/24 at 6:28 PM, the surveyor observed Resident #60 in the hallway, the resident was alert and oriented and engaged the surveyor.<br><br>On 07/16/24 11:02 AM, Reisdent #60 stated to the surveyor that there has been concerns that were shared with the Liscensed Nursing Home Admininstrator (LNHA) and there has not been resolution. The facility is very disorganized and the staff takes extended time to answer the call bell and it is hard to find them.<br><br>The surveyor reviewed the medical record for Resident #60.<br><br>A review of the Admission Record Face Sheet reflected the resident was admitted to the facility with diagnoses, which included but not limited to unsteadiness on feet, weakness, pure hypercholesterolemia (high cholesterol), acute kidney failure, bipolar disorder in full remission most recent episode mixed (mental health condition), hypertension (high blood pressure), and benign prostatic hyperplasia without lower urinary tract symptoms.<br><br>A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 2/20/24, reflected the resident had a brief interview for mental status score of a 15 out of 15, which indicated a fully intact cognition.<br><br>On 7/16/24 at 2:30 PM, the surveyor reviewed a facility provided Grievance form for Resident #60 dated 11/22/22 at 6:30 PM. The Grievance form revealed:<br><br>Staff Member receiving Concern: [name redacted], Human Resource Director (HRD) and [name redacted], Receptionist.<br><br>Section 1: Describe the Nature of the Concern: upset not enough staff. Certified Nursing Aides (CNA) are so shorthanded. Resident puts light on, as needs help to the bathroom. No one comes. It's middle of night. CNA outside room making fun of resident. [Resident #60] needs to pee pee on [themselves] because they don't come. Unhappy with night shift. No one helps, day shift fine, night shift terrible.<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 - Many | Section 2: Concern Referred to Department Head for Review and Intervention:<br><br>Section 2 of the Grievance form, was not addressed; all sections were left blank. The sections that were left blank included: Department head, Date, Review and Action Taken.<br><br>Section 3: Follow up with Resident/Family Member: Issue last night was that bed wasn't made and CNA denied this even though bed wasn't made.<br><br>Name of Staff Completing Follow-up: Name redacted (Social Worker) dated 11/23/22<br><br>Section 4: Further Action Required and/or New Grievance Generate<br><br>Concern and/or Grievance Resolved<br><br>Section 4 of the Grievance form was not addressed; there was no check mark that indicated that the grievance needed further action or that the grievance was resolved.<br><br>The Grievance Form was signed by the Director of Nursing (DON), dated 11/22/22.<br><br>On 7/17/24 at 9:41 AM, the surveyor conducted a follow-up interview with Resident #60 about the Grievance that was filed on 11/22/22. The Resident stated that their memory was off sometimes and did recall however, that it was possible that the staff made fun of [them] and laughed. Resident #60 further stated that the staff often had attitudes, make faces, and ignore the residents. The Resident stated that they went, to the LNHA in the past about issues, and the LNHA does not do anything about it, This place is the most disorganized place in my life.<br><br>On 7/17/24 at 12:40 PM, the surveyor interviewed the DON and the LNHA in the presence of the survey team. The LNHA and the DON were both made aware of the incomplete Grievance Form for Resident #60. The DON confirmed that it was an allegation of abuse. The surveyor requested all additional documentation regarding of the grievance that was filed by Resident #60 for verbal abuse.<br><br>On 7/17/24 at 1:25 PM, in the presences of the survey team, the surveyor interviewed the DON who stated that she spoke with the resident and that is what I have, nothing more regarding the investigation. The DON then provided a copy of a Employee's Statement of Incident, with the DON Signing as the Employee. The DON then confirmed that she was the person who also signed the incomplete Grievance Form. The DON further stated that no investigation was completed and that she only spoke with the resident. The DON confirmed that she had nothing else to provide.<br><br>The DON's Statement of Incident Form dated 11/25/22, revealed:<br><br>Type of Incident:<br><br>__Fall __Skin Tear __Bruising __Facture<br><br>Other Type of Incident: [Possible] Verbal Abuse<br><br>IN YOUR WORDS DESCRIBE THE INCIDENT BELOW, INCLUDE WHHAT HAPPENED, WHO WAS INVOLVED, WHERE IT HAPPENED, WHY IT HAPPENED, WHEN REPORTING WHAT OTHER HAVE SAID USE QUOTES. SIGN AND DATE THE FORM.<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 - Many | Employee's Statement:<br><br>Resident #60 came to me laughing saying I pee pee on myself. There was not enough staff.<br><br>I had a conversation with Resident #60. I asked them if they were alright. Did someone hurt your feelings? They said no, they were joking about it.<br><br>Resident #60 said we need more staff, I explained we are trying to hire. I told Resident #60 if anyone hurts their feelings to come to me. They waived their hand and said, I don't care.<br><br>Follow up: spoke with staff, all denied him complaining.<br><br>I see Resident #60 daily and will continue following up.<br><br>Signed by the DON<br><br>The DON did not provide any additional statements regarding any other staff, residents, including a roommate that may have been present. Additionally, the DON failed to further address the resident's staffing concerns which were consistent with the concerns expressed to the surveyor 1.5 years later.<br><br>On 7/17/24 at 1:43 PM, the surveyor interviewed the HRD who stated that she was standing there with the receptionist when Resident #60 came up to file a grievance. The HRD explained that they follow the chain of command, and she was told by the DON and LNHA that it was handled.<br><br>On 7/18/24 at 6:58 PM, surveyor had a telephone interview with the receptionist who was present with the HRD, when Resident #60 wanted to file a grievance. The receptionist stated that the resident was very upset because the staff were laughing at them in the hallway. She stated, [Gender redacted] is someone that does not fabricate stories and if he comes with a complaint, I believe him. The receptionist stated she either put the grievance form in the LNHA's or Social Workers mailbox.<br><br>b) On 07/15/24 at 9:15 AM, the surveyor reviewed the closed medical record for Resident #295 which revealed: An Admission Record that indicated the resident was admitted on [DATE] with diagnoses that including, but not limited to: Acute Respiratory Failure, Nontraumatic Intracranial hemorrhage, Unspecified, and Pulmonary Embolism. The Order Summary Report dated 11/09/22 revealed the Resident was a Full Code.<br><br>An admission note, dated 11/09/22 at 14:29 and signed by a Licensed Practical Nurse (LPN) revealed Time of arrival 1:40 PM and medications confirmed and verified by the physician.<br><br>A Physician Progress Note, Effective Date: 11/10/22 at 14:20 revealed that Patient AAO (Awake Alert and Oriented) X 3 but has periods of disorientation when asking history.<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 - Many | A General Nurses Note, Effective Date 11/10/2022 at 20:57 [8:57 PM] and signed by Registered Nurse revealed: Note Text: Resident was received in bed at the beginning of shift this afternoon in bed watching TV in no acute distress, second day post admission adjusting well to service prior to this incident today. Nurse observed resident 10 minutes before being discovered. CNA [Certified Nurse Aide] was in resident's room to deliver dinner when the resident could not be found and the CNA called the resident's name while checking the bathroom until the CNA walked around the window side of the bed and discovered the resident on the floor in supine position with the folded jacket under the head and breathing but very difficult to arouse. Supervisor arrived to the scene and met an [AGE] year old female snoring heavily saturated with urine, the resident was first assessed on the floor placed on left side in a recovery position in case of emptying stomach content all vital signs were within normal limit including O2 at 98-99%. Resident was placed in bed while code status was confirmed as full code and 911 activated.<br><br>The surveyor then reviewed the requested investigation provided by the Director of Nursing (DON) on 07/15/24 at 9:00 AM. The investigation revealed: Fall, Dated 11/20/2022 Nursing Description: Resident was observed on the floor next to the radiator in a supine position with head over a folded jacket snoring heavily, very difficult to arouse and non-responsive to call or touch. Resident Description: Unable to Obtain. Immediate Action Taken: Vital signs were all within normal limits . Resident was assisted to bed and place on non-rebreather mask as 911 was activated. Injuries Observed at Time of Incident, no injuries observed at time of incident. The Predisposing Physiological, Environmental and Situation Factors were all left blank. The Other info [information section] revealed Incident was unwitnessed. [Resident] was seen in bed by aide moments later went to serve dinner and located on the floor. Statements: No Witnesses Found. Progress Note 11/10/2022 at 20:57 [8:57 PM] attached to investigation. No witness statements, including statement from the CNA, no summary and conclusion regarding unwitnessed fall, including how the resident was found lying on their back with a jacket under their head like a pillow.<br><br>On 07/15/24 at 1:45 PM, the surveyor interviewed the DON in the presence of the survey team, in presence of Licensed Nursing Home Administrator (LNHA) regarding the incomplete investigation and lack of statements. The DON stated that she told the regional that in the beginning of 2023 that she did not like the new process for investigations. The DON stated that for years they used the blue folder system and now they were told that the investigation had to be in the risk management system and it didn't feel complete, and now, if there was a witness, it would be type in. The DON stated I never had an issue with incident reports ever because for injuries of unknown origin we would investigate then. The DON stated she would look to see if she had anything else.<br><br>On 07/15/24 at 2:20 PM, the DON informed the surveyor that what was provided for Resident #295 was all that she had and confirmed no other statements were taken and no other documentation regarding an investigation was completed.<br><br>The Incidents and Accidents Policy, dated 1/2024, revealed it is the policy of this facility for staff to report, investigate, and review and accidents or incidents that occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident: refers to any unexpected or unintentional incident, which result or may result in injury or illness to a resident. Incident: is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member.<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 - Many | Policy explanation: The purpose of incident reporting can include Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administrator of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 3. Incidents or accidents involving employees or visitors will be documented per the facility policy. 4. Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed, and reported according to the facility's abuse prevention policy.<br><br>A review of the facility's policy titled, Abuse Investigation and Reporting reviewed, and updated on October 2022, revealed the following:<br><br>All reports or resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.<br><br>Abuse, Neglect and Exploitation Policy, dated 07/12/23 revealed: v. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegation. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.<br><br>Role of Administrator:<br><br>- If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual.<br><br>- The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation.<br><br>- The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of investigation.<br><br>- The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented.<br><br>- The administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident.<br><br>NJAC 8:39-27.1 (a) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193<br><br>Based on record review and interview, it was determined that the facility failed to accurately assess Resident #74 for a behavior management program which would address the behavior of wandering and urinating on the floor/other residents's rooms. Resident #74 exhibited these behaviors since December 2023. The facility failed to revise the care plan to include meaningful interventions to address these behaviors. This deficient practice was observed for 1 of 3 residents reviewed for management of behaviors (Resident #74) and was evidenced by the following:<br><br>On 07/15/24 at 8:30 PM, two awake and alert residents, reported that they were disturbed by Resident #74's behavior of wandering into their rooms and displacing their belongings. The wandering resident was identified as Resident #74 who resided on the back of the A Wing of the facility. A Certified Nursing Assistant (CNA ) who reported that she had a good rapport with Resident #74 confirmed the behavior and informed the surveyor that the red stop signs were applied to prevent Resident #74 from entering other residents rooms. However that did not stop Resident #74 from entering other residents rooms.<br><br>On 07/17/24 at 10:30 AM, the surveyor reviewed Resident #74's electronic medical record (eMR). A review of Resident #50's Admission Record (An Admission Summary) reflected that Resident #74 was admitted to the facility and had diagnoses which included but were not limited to; vascular dementia, major depressive disorder, cerebral infarction. and generalized anxiety disorder.<br><br>A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 06/15/24, reflected that Resident #74 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident's cognition was severely impaired. A further review of the resident's MDS, Section E - Behavior indicated that E 0900 which referred to wandering was coded as zero.<br><br>A review of Resident #74's Care Plan revised on 09/19/23, reflected a focus area that Resident #1 had impaired cognitive function/dementia or impaired thought processes related to Dementia. The goals of the resident's Care Plan was Resident #74 would improve current level of cognitive function through the review date of 06/06/24, initiated on 09/14/23.<br><br>Resident #74 will maintain current level of cognitive function through the review date, initiated on 09/14/23.<br><br>Resident #74 will be able to communicate basic needs on a daily basis through the review date, initiated on 09/14/23.<br><br>Resident #74 will develop skills to cope with cognitive decline and maintain safety by the review date, initiated on 09/14/23.<br><br>Resident #74 will maintain current level of decision making ability by review date, initiated on 09/14/23.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #74 also had a focus for elopement risk/wanderer Resident #74 wanders aimlessly throughout the unit.<br><br>The goal for Resident #74 reflected, that the resident will not leave facility unattended through the review date, initiated on 02/27/24.<br><br>The interventions included:<br><br>-Assess for fall risk. Initiated 02/27/2024.<br><br>-Distract Resident #74 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Initiated 02/27/2024.<br><br>-Monitor for fatigue and weight loss. Initiated 02/27/2024.<br><br>-Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Initiated 02/27/2024.<br><br>-Wander alert to left ankle; Initiated 02/27/24.<br><br>-The Care Plan for Activities initiated 05/10/2024 included the following<br><br>-Resident #74 enjoyed music/ social events and does eat lunch in the dining room.<br><br>-Resident #74 will have the opportunity to enjoy activities of choice. Initiated 05/10/2024. Interventions included:<br><br>-Invite Resident #74 to all activities of interest. Initiated 05/10/2024.<br><br>-Notify nurse of all negative behaviors that occur during activities, regardless of redirection outcome.<br><br>-Staff to assist Resident #74 to attend activities as desired.<br><br>On 07/17/24 at 11:30 AM, the surveyor further reviewed Resident #74's clinical record and noted several nurse's notes which confirmed the wandering behavior, the behavior of urinating in other residents rooms, and taking other residents' snacks.<br><br>A psychiatry progress notes written on 11/2/23 revealed the following: As per reports, Resident #74 -had periods of anxiety, requiring frequent redirection.<br><br>A psychiatry progress note dated 02/22/2024, indicated the following: Resident #74 often wanders into other resident's rooms but is easily redirected.<br><br>Another psychiatry note dated 05/16/2024 indicated, As per reports, Resident #74 has had continued difficulty sleeping at night, attempting to enter other residents rooms.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A behavior note dated 12/03/2023 timed 18: 23 [6:23 PM ] Pacing up and down the hallways going into other residents room taking their belongings, difficult to redirect.<br><br>A behavioral note dated 1/25/24 timed 07:21 AM, revealed: Resident #74 alert with confusion, continent and ambulatory. Monitored closely, 30 minutes watch, to ensure their safety and the safety of others. Resident #74 went to the hallway once and was redirected. At 4:35 AM, Resident #74 went into Room A 31's bathroom and was redirected by this writer into their bathroom. Left in their bed at 7:00 AM.<br><br>On 02/29/24 at 13:55 [1:35 PM] a Progress Notes written by a Registered Nurse (RN) reflected that a CNA observed Resident #74 on the floor in room [ROOM NUMBER]. Resident #74 reported right hip and rib pain. The facility did not indicate how Resident #74 was able to wander into another resident's room and staff was not aware. According to the note, Resident #74 was placed on 2 hours monitoring. The facility did not investigate further to rule out abuse.<br><br>On 03/25/24 at 00:56 [12:56 AM] the LPN documented a the behavioral note: Continues to wander into other residents rooms, touching their belongings, eat their food and urinate in hampers.<br><br>On 03/27/24 at 07:28 AM the LPN documented, Resident #74 continues to wander into other resident's room and taking their stuff, eat their food and urinate in their rooms. Resident #74 is very difficult to redirect. Resident #74 starting on 2 hours monitoring. Resident likes to pacing up and down the unit.<br><br>On 07/14/24 at 6:30 PM, and 07/18/24 at 9:30 AM, Resident #50 reported that Resident #74 continued to enter their room and urinated in their trash can.<br><br>On 07/16/24 at 10:30 AM, the surveyor interviewed Resident #74's roommate regarding the behavior. The roommate confirmed the behavior, and added that Resident #74 kept them up most of the night which interfered with their sleep. Resident #74 will turn off their Bipap machine (machine that helps with breathing) and rummaging through their belongings.<br><br>On 07/18/24 at 11:30 AM, the surveyor interviewed the LPN/Unit Manager. The LPN/UM confirmed the behavior. The LPN/UM stated that another resident resided in the room, prior to Resident #50 and she was aware that Resident #74 frequently entered the same room and urinated into their trash can. She was not aware that Resident #74 continued to enter Resident #50's room and continued to urinate into their trash can. When asked, how the behavior was addressed, she indicated that stop signs were placed at the door entrance for residents who expressed concerns over the wandering behavior.<br><br>On 07/18/24 at 12:15 PM, the Nurse Practitioner and the LPN/UM confirmed the behavior of wandering and urinating in the room and in other residents' trash cans.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/18/24 at 12:25 PM, the surveyor reviewed Resident #74's Care Plan with the LPN/UM. The Care Plan initiated on 02/27/24 addressed elopement. The Care Plan did not address the behavior of wandering and urinating into other residents rooms. Resident #74, exhibited behavior of wandering into other residents room especially at nights, taking their snacks since December 2023. The interventions included, provide structured activities, distract from wandering .provide picture and memory boxes. The facility was unable to provide evidence of non pharmacological interventions implemented to address the behavior of wandering and urinating into other resident's room. The LPN/UM stated there was no scheduled activity at night. The Care plan failed to address the line of supervision required for Resident #74. Furthermore, the behavior of urinating on the floor and into the receptacle bin was not addressed in the Care Plan.<br><br>On 07/18/24 at 1:30 PM during an interview with the Certified Nursing Assistant (CNA) she confirmed the behavior of urinating on the floor. The CNA revealed she never witnessed the behavior as Resident #74 exhibited the behavior on 3-11 and 11-7. The CNA further stated that Resident #74 was mostly continent during the day.<br><br>N.J.A.C.8:39-11.2(e) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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** 27193<br><br>Complaint #NJ 00175040<br><br>Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide a.) appropriate incontinence care, and personal hygiene care for 8 of 23 residents (Resident #2 and #31) unsampled residents, #9, #24, #30, #39, #50, #63, and #64, sampled on 2 of 4 resident units. The deficient practice was evidenced by the following:<br><br>On 07/14/24 around 6:15 PM, the surveyor toured the North Wing of the facility. At 6:30 PM the surveyors entered the A Wing, a strong malodorous odor of urine and feces was permeated in the hallway. The surveyor observed Resident #63 sitting in a recliner chair by their door. Resident #63 could not speak, was mumbling and scratching. Resident #63 was unable to answer any question.<br><br>1. On 07/14/24 at 6:24 PM, the surveyor observed Resident #39 in bed by the door. Resident #39, stated, I need help. The surveyor observed another resident exited the room, the resident hold their nose and stated that Resident #39 needed to be seen by a doctor. A strong feces odor was noted in the hallway leading to Resident #39's bed.<br><br>The surveyor observed a Certified Nursing Assistant (CNA) in the next hallway and summoned her to the room. The surveyor informed the CNA that she would like to perform a care tour. The CNA entered the room, checked Resident #39 for incontinence. Resident #39 was soiled with feces and had some redness on the coccyx area. According to staff, Resident #39 was just readmitted to the facility on [DATE]. The CNA informed the surveyor that she reported to work at 4:30 PM, and had not provided care yet to some of the residents.<br><br>Review of Resident #39's plan of care revealed a focus area for limited physical mobility related to weakness. The interventions were to provide supportive care, assistance with mobility as needed. Resident #39 although dependent on staff for care did not have a focus for their Activities of Daily living.<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 - Many | 2. At 6:45 PM the surveyor entered Resident #50's room. Resident #50 was awake and alert. When asked how was the care at the facility, Resident #50 stated, Not good. The surveyor asked Resident #50 to elaborate. Resident #50 stated, I have been waiting to be changed since after lunch, and still nothing had been done. Resident #50 informed the surveyor that they were changed around 6:30 AM, this morning. They activated the call light to inform staff that they needed to be changed. A staff answered the call light and stated that they will provide incontinence care after lunch. They never come to the room to assist. Resident #50 stated that they have been sitting in their excrements since this morning and that was not right. The surveyor left the room and informed the Licensed Practical Nurse (LPN) observed on the medication cart. The LPN stated that she will be in with a CNA to provide care. The LPN and two CNAs entered the room to provide care. Resident #50 was soaked with urine, the bedding, gown, the pulled sheet, the bed protectors were yellow stained and soiled with urine. The surveyor asked the LPN to call the Director of Nursing (DON ) in the room. At 6:45 PM, the DON entered the room and Resident #50 informed the DON that he had not been changed since 6:30 AM this morning. The DON asked the resident if they activated the call light. The resident informed the DON they activated the call light and was told that incontinence care will be offered after lunch. No staff reported to the room to offer incontinence care. The surveyor and the DON both observed that Resident #50 an awake and alert resident had double briefs on which were saturated with urine. The bedding, gown and under pads were all saturated with urine. 12 hours had elapsed since incontinence care was provided according to Resident #50.<br><br>Resident #50 was dependent on staff for care. A review of Resident #50's comprehensive Care Plan did not address Activities of Daily Living (ADLs).<br><br>On 7/14/24 at 7:00 PM, the surveyor continued with the incontinence tour. The surveyor and the CNAs observed Resident #64 in bed, soaked with urine. Resident #64 had two adult briefs on which were saturated with urine. The bedding was soaked with urine. Resident #64 informed the surveyor that they had not been changed since this morning.<br><br>3. On 7/14/24 at 7:10 PM, Resident #63 was still sitting in the hallway. 2 CNAs transferred Resident #63 in bed via the Hoyer Lift (assistive device that allows patients in hospitals and Nursing homes and people receiving home health care at home to be transferred between a bed and a chair or other similar resting places).<br><br>The surveyor observed that the sling was soaked with urine. Resident #63's pants were soaked with urine. The Assistant Director of Nursing (ADON) was called to the room and verified the same. Upon removing Resident #63's pants to provide care, the CNAs, the ADON and the surveyor, we all witnessed that Resident #63 had 3 adult briefs on which were saturated with urine and feces. Resident #63 had some redness on the sacrum area and was scratching when the soiled briefs were removed.<br><br>The surveyor then asked the ADON what was her expectations regarding incontinence care; the ADON stated, All residents should have on one adult brief.<br><br>Resident #63 was totally dependent on staff for care. Resident #63 assessed by the facility as having impaired cognitive function related to Alzheimer's was totally dependent on staff for care. Resident #63 did not have a care plan in place to address incontinence care.<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 - Many | 4. On 7/14/24 at 7:25 PM, two CNAs transferred Resident #24 to bed for incontinence care. The surveyor entered Resident #24's room. During incontinence care, Resident #24 was soiled with urine and feces. The staff could not indicate when Resident #24 was last changed.<br><br>Review of Resident #24's care plan revealed a focus for aphasia ( inability to speak ). Resident #24 communicates through gestures. The goal was for Resident #24 will communicate needs and preferences throughout the day effectively through the next review. There was no care plan in place to address Resident #24's ADLs.<br><br>5. On 07/14/24 /24 at 7:45 PM, the surveyor observed Resident #31 sitting by the door in their room. When asked about the care received at the facility, Resident #31 stated, incontinence care was not provided in a timely manner, call light not answered timely. Resident #31 stated, it could take 45 minutes to one hour for staff to answer the call light. During the interview, Resident #31's nails were noted to be long and jagged. Resident #31 informed the surveyor that they would like their nails to be trimmed and cleaned.<br><br>6. On 07/14/24 at 08:15 PM, the surveyor entered Resident #2's room with the Unit Manager (UM) and the CNA. At the surveyor's request, Resident #2's incontinent brief was checked by staff. Resident #2 was soiled with feces and urine. The resident had redness all over the back and the buttocks area. The UM assisted with incontinence care and applied some ointment to the affected areas.<br><br>07/16/24 at 09:13 AM, the surveyor returned to the North Wing and observed Resident #3's nails not being trimmed and cleaned. The Surveyor again asked Resident #31 if they would like their nails to be trimmed and cleaned, Resident #31 stated clearly, That would be nice, I would look like a lady.<br><br>7. On 07/16/24 at 9:45 AM, the surveyor made another random care tour with a CNA. Resident # 63 and Resident #64 both were soaked with urine. Resident # 63 and Resident #64 both were dependent on staff for care.<br><br>On 07/16/24 at 11:55 AM, the surveyor interviewed the Director of Nursing (DON )regarding the issues with incontinence care observed on 07/14/24 during the care tour. The DON stated that Resident #50 should not have had on two adult incontinence briefs. The DON acknowledged that Resident #50 needed assistance with care, hygiene, transferring and toileting, was incontinent of bowel and bladder. The DON further stated that she would investigate and address the above concerns.<br><br>On 7/16/24 at 12:56 PM, the DON provided a statement from the CNA who worked the 7:00 AM-3:00 PM shift on 7/14/24. The CNA indicated in the statement that Resident #50 received care at 9:00 AM and she last checked Resident #50 at 2:00 PM. However, during an interview on 7/16/24 at 1:15 PM, the CNA informed the surveyor that she worked from 7:00 AM -1:30 PM everyday, and the facility was aware. The staffing Coordinator confirmed that CNA #1 was to work until 2:00 PM but if she took her break at the end of the shift, she would exit the facility at 1:30 PM. On 7/16/24 CNA #1 informed the surveyor that she provided care to Resident #63 at 10:30 AM and transferred Resident #63 to the chair at 12:30 PM on 7/14/24. Resident #63 received incontinence care at 7:15 PM, almost 9 hours later. According to the facility, incontinence care was to be provided every two hours and as needed.<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 - Many | On 07/18/24 at 10:30 AM, the surveyor interviewed the CNA who had Resident #50, 63, and 24 on their assignment on 7/14/24 during the 7:00 AM- 3:00 PM shift. The CNA confirmed that she applied extra briefs on the residents. When asked about the policy for incontinence care, she stated that all residents should have one incontinence brief on. In the statement provided, the CNA indicated that she provided care to Resident #50 at 9:00 AM and last checked Resident #50 at 2:00 PM. However, during the interview with the surveyors she stated that on 7/14/24 she exited the facility at 1:30 PM. The CNA further stated that she worked from 7:00 AM- 1:30 PM, every day and the facility was aware.<br><br>On 07/18/24 at 10:38 AM, during an interview with the Staffing Coordinator, she confirmed that CNA #1 worked from 7:00 AM-1:30 PM. The staffing Coordinator added that if CNA #1 took their break at the end of the shift, CNA #1 would exit the facility at 1:30 PM.<br><br>On 07/18/24 at 12:11 PM, the surveyor interviewed the Unit Manager (UM) and inquired regarding who was responsible to cover CNA #1's assignment after 1:30 PM, the UM did not have any comment.<br><br>8.) On 07/15/24 at 9:46 AM, the surveyor entered Resident #30's room and noted a strong odor of urine. Resident #30 was awake and alert at the time and informed the surveyor that they had been soiled with urine since 4:00 AM that morning. Resident #30 indicated that this situation was not an isolated incident and had occurred numerous times in the past. Additionally, Resident #30 stated that they were often left sitting in wet conditions throughout the day and they have used double diapers in the past.<br><br>The resident activated the call bell, which was subsequently addressed by the Unit Manager Registered Nurse (UMRN) and Certified Nursing Assistant (CNA). During this observation and interview, both the UMRN and the CNA confirmed that the resident was found saturated in urine. The UMRN expressed that this situation is unacceptable and indicated that incontinence rounds should be conducted every two hours to prevent such occurrences.<br><br>9.) On 07/14/24 at 7:23 PM During an initial tour of A Wing Back, the surveyor identified a strong, pervasive odor in the hallway. Upon entering Resident #9's room, which was observed in the presence of another surveyor and a CNA, it was determined that the odor was originating from this resident's room. The surveyor observed that the resident's bed was visibly soaked with urine, and there was a noticeable brownish-yellow discoloration around the perimeter of the bed sheet.<br><br>On 07/18/24 at 9:45 AM, the surveyor walked down the hallway of A Wing Back and detected a strong, pervasive odor that was coming from Resident #9's room. Upon entering Resident #9's room, the surveyor observed that the room was disorganized, with a cooler, a breakfast tray cover, and a trash bag on the bed. Additionally, the resident's sheets were saturated in urine and had a brownish-yellow discoloration.<br><br>When the resident was asked if they needed to be changed, the response was, I have no idea if I'm wet.<br><br>07/19/24 09:48 AM, the surveyor observed Resident #9 lying in bed with a strong odor present in the room. A blue bed protector, which was saturated in urine, was stuffed in the corner of the bed against the wall beside the resident. The resident was laying on the bed without any sheets covering the mattress.<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 - Many | A review of the Bowel & Bladder Program Screen Quarterly for Resident #9 dated on 6/21/2024 revealed the following:<br><br>Section E. Mentally aware of need to toilet<br><br>-Sometimes aware of need toilet<br><br>A review of the Psychotropic Monthly Quarterly Summary for Resident #9 dated 7/3/2024 revealed the following:<br><br>Section 8. Include Sleep Patterns, Socialization, ADLs, Mood Changes, Severity of Behaviors ETC<br><br>Resident #9 is out of bed daily and ambulates the hallway independently. They are able to make there needs known. They are usually pleasant but can become overwhelmed and shows signs of anxiety or aggression toward staff but can be redirected. They have a good appetite and sleeps on and off during the day and at night. They like snacks that are offered throughout the day and attempts to go on a search for more during the night. Requires assistance with ADL's. No unusual behaviors noted. Medication is effective and plan of care continues.<br><br>On 07/16/24 at 10:48 AM, the surveyor conducted a resident counsel meeting with 11 residents. All 11 residents expressed concerns that the facility does not have adequate staffing to meet their needs. One resident indicated they are very reluctant to change your diaper unless its closer to 5 AM in the morning. The same resident reported that staff typically change residents' diapers before the shift change. In the morning, when getting them out of bed they are changed, but then do not provide further changes until 2 PM. On the 3-11 PM shift staff are often late and do not perform necessary changes until the resident is in bed. Another resident stated that staff during the 3-11 PM shift are rarely around, and the situation is so severe that they can smell the urine and feces in the hallways.<br><br>A review of the facility's policy for Incontinence care reviewed October 2023, revealed the following:<br><br>Policy Statement<br><br>Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services.<br><br>Policy Interpretation and Implementation<br><br>#4 The facility must ensure that residents that are incontinent of bladder and bowel will receive appropriate treatment to prevent infections and restore continence to the extent possible.<br><br>The facility's policy for Activities of Daily Living (ADLs) updated October 2023, revealed:<br><br>The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL do not deteriorate unless deterioration is unavoidable.<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 - Many | Care and services will be provided for the following activities of daily living:<br><br>Bathing, dressing, grooming and oral care.<br><br>Transfer and ambulation.<br><br>Toileting.<br><br>Policy Explanation and Compliance Guidelines<br><br>A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>All ADLs will be documented at a minimum daily in resident record.<br><br>On 07/18/24 at 11:30 AM, the DON provided in-serviced education that was done on 7/14/24 to address double incontinence brief. The DON stated that the staff was -in-serviced. The DON also added that her expectations were that all residents would be turned and changed every two hours and as needed. The facility management indicated that they were not aware of concerns with incontinence care and residents wearing double incontinence brief.<br><br>The above concerns with nails and incontinence care were discussed with the facility management during the survey and again on 07/18/24 prior to the exit conference. The DON indicated that the staff were in -serviced.<br><br>NJAC 8:39-27.1(a), 27.2(g) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449<br><br>Complaint#'s NJ159619, NJ173589<br><br>Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs by failing to: a) ensure a procedure was in place prior to caring for a resident who required an Inotropic (intravenous medication used for heart failure) medication that required specific monitoring and b) to ensure a system was in place to provide physician ordered cardiac medications for a newly admitted resident. This deficient practice was identified for two 2 of closed records reviewed for quality of care, (Resident #296 and #297) and was evidenced by the following:<br><br>Refer 755 D<br><br>a) Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that meet each resident's physical, mental and psychosocial needs by failing to: a) ensure a procedure was in place prior to caring for a resident who required an Inotropic (intravenous medication used for heart failure) medication that required specific monitoring and b) to ensure that staff were trained to monitor and administer the medication according to the physician's order for a newly admitted resident. This deficient practice was identified for two 2 of closed records reviewed for quality of care, (Resident #296 and #88) and was evidenced by the following:<br><br>Refer 755 D<br><br>a) On 07/15/24 at 9:00 PM, the surveyor reviewed Resident #88's Electronic Medical Record (EMR) which revealed:<br><br>On 7/2/2024 15:52 [3:52 PM] MD/APRN/PA/NP General Note revealed:<br><br>Note Text: PHYSICIAN PROGRESS NOTE (completed by the physician who was also the medical director)<br><br>DATE OF SERVICE: 07/02/ 24<br><br>admitted : 06/11/ 24<br><br>Patient is a 75 y/o PMH of dilated CM (cardiomyopathy- heart has difficulty pumping blood) and chronic systolic CHF (Congestive Heart Failure) EF (ejection fraction) 15-20% with CAD hex CABG (heart bypass) 2007, HTN, hyperlipidemia, DM type 2. was admitted to [hospital] from 05/15 to 06/10 with fatigue and SOB [shortness of breath] and found to have fixed defect on stress test. underwent left and right heart cath [catherization], wide complex tachy [fast heart beat] given amiodarone, low BP on pressors and VDRF. was initiated on milrinone (Inotropic) . PICC (percutaneously inserted central catheter- in arm to give intravenous medications to central vein) line RUE for milrinone drip. Now admitted for SAR.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | REASON FOR VISIT AND INTERVAL HX:<br><br>f/u [follow up DM ( diabetes mellitus, management monitor, CHF(Congestive Heart Failure management and milrinone . DC planning<br><br>Patient seen in rehab gym tolerating exercises and feeling well . Appetite is good. BP and HR in usual control. DC planning in progress may be for end of this week .<br><br>MEDICATIONS: reviewed and reconciled<br><br>PHYSICAL EXAM:<br><br>Vital Signs BP 113/80 HR 64 RR 18 TEMP 98.5 O2 97%<br><br>ASSESSMENT/PLAN:<br><br>-ongoing monitor on milrinone drip with VS (vital signs) q (every) 4 hours and weekly labs and send to cardio .<br><br>thus far BP (blood pressure) ok and no c/o (complaints of) lightheadedness<br><br>DC planning in progress, DW UM [Discussed with Unit Manager] script for milrinone from cardio, other scripts were completed.<br><br>Planned home care on DC.<br><br>FACE TO FACE DOCUMENTATION FOR HOMECARE:<br><br>Need for skilled services:<br><br>PT and OT for ongoing gait and ambulation training and strengthening and endurance. RN for med education and oversight and BP and HR monitor on cardiac med and monitor on IV milrinone coordination of care with cardio. RN for healthcare teaching, DM mngt, wound care.<br><br>Pt deemed homebound because:<br><br>Needs assuasive device for safe ambulation with decreased endurance and limited mobility. Therefore, needs assist of another to leave home safely and taxing effort to leave the home.<br><br>Follow up with PCP and cardiology and specialists as directed.<br><br>A 7/2/2024, 07:51 eMAR- Medication Administration Note<br><br>Note Text: Weigh every am at 6am. If weight gain or loss of ten pounds, call cardiologist for milrinone adjustment.<br><br>one time a day<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | A 7/3/2024 08:21 General Nurses Note<br><br>Note Text: Patient alert and speaking this AM, no complaints voiced on 7AM rounds. At approximately 8am, patient non responsive. BP 57/27, so2 90%. Milrinone pump running as ordered. 911 called for transfer to ER [emergency room ] for evaluation. Oxygen applied via non-rebreather. Patient improved some, opening eyes. MD [medical doctor] and [spouse] made aware.<br><br>A 7/3/2024 08:47, General Nurses Note<br><br>Note Text: 7:30am- Nurse went into room to check BS [Blood Sugar], pt [Patient] was responsive and alert. BS 285, 7 units [insulin] administered per order, 8:15am Nurse called into room pt was cyanotic (bluish skin discoloration resulting from poor blood oxygen level), unresponsive, vitals checked 56/27 [blood pressure] p. 42 [pulse] 02 [oxygen] 67% [oxygen level %- normal 100%]. Non rebreather [emergency oxygen mask] applied and vital checked continuously. Once 02 applied pt become responsive with physical tactile stimuli. 911 was called by UM [unit manager] and ADON [assistant director of nursing]. Nurse stayed with pt until EMS [emergency medical services] arrived. Vitals as pt left 70/43 p.64 02 98%<br><br>8:50 am Patient transported to [Hospital Name] via EMS.<br><br>7/3/2024 08:52 General Nurses Note<br><br>Note Text: 911 arrived on scene, assessed patient, and decided to transport him to MMC, due his cardiac program. His wife, MD and heart wellness were all made aware of the transfer<br><br>The Order Summary Report: June 11, 2024- July 3, 2024, revealed:<br><br>Order Start Date: 06/28/24: Milrinone Lactate in Dextrose Intravenous Solution 20-5 MG/100ML-% (Milrinone Lactate in Dextrose) Use .25 mcg intravenously every 48 hours for Hear failure .25 mcg/min Intravenously every 48 hrs. change bag/make sure the IV bag does not go empty.<br><br>The Medication Administration Record for June and July 2024 revealed an order for Vitals Signs Every 4 [6 times] Hours X 7 Days, every day and evening shift for monitoring Routine 2 to start after Route 1, Order Dated: 06/11/2024 17:10 [5:10 PM]. The Vitals, which included, Blood Pressure, Temperature, Pulse, Respirations, and O2 Saturation were documented from 6/12/24 through 06/18/24 on the MAR. There was no documentation on the MAR from 06/19/24 through 06/30/24 for the Vitals, the MAR was left blank, and there were no specific parameters to contact physician regarding Blood Pressure levels.<br><br>The 3-page Vitals Report, Blood Pressure Summary Dated 6/11/24 through 07/03/24 revealed:<br><br>06/19/24-2 Readings:<br><br>15:29: 94/66 mm/hg [millimetre of mercury; unit of pressure]<br><br>16:15: 110/62 mm/hg,<br><br>06/20/24-1 Readings:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 11:23, 100/59 mm/hg *Diastolic Low of 60 exceeded<br><br>06/21/24-3 Readings:<br><br>1:49 100/49 mm/hg<br><br>14:22, 89/52 mm/hg * Systolic low of 90 exceeded, Diastolic Low of 60 exceeded<br><br>-16:44 105/53 mm/hg Diastolic Low of 60 exceeded<br><br>06/22/24-2 Readings:<br><br>8:30 100/58 mm/hg, 19:23 102/57 mm/hg * Diastolic Low of 60 Exceeded<br><br>06/23/24-2 Readings:<br><br>11:56 114/63 mm/hg<br><br>21:51 122/73 mm/hg<br><br>06/24/24-2 Readings:<br><br>16:20 100/58 mm/hg, *Diastolic Low of 60 Exceeded<br><br>21:32 100/55 mm/hg * Diastolic Low of 60 Exceeded<br><br>06/25/24-2 Readings:<br><br>8:29 164/99 mm/hg *Systolic high of 139 exceeded. Diastolic high of 89 exceeded.<br><br>18:16 105/69 mm/hg<br><br>06/26/24-2 Readings:<br><br>16:12 105/66 mm/hg<br><br>17:19 96/54 mm/hg * Diastolic Low of 60 Exceeded<br><br>06/27/24-2 Readings:<br><br>7:02 105/60 mm/hg<br><br>17:07 121/89 mm/hg<br><br>06/28/24-2 Readings:<br><br>12:24 93/56 mm/hg *Diastolic Low of 60 Exceeded<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 18:43 95/58 mm/hg *Diastolic Low of 60 Exceeded<br><br>06/29/24-2 Readings:<br><br>10:20 106/62 mm/hg<br><br>18:22 87/58 mm/hg *Systolic low of 90 exceeded, Diastolic Low of 60 exceeded<br><br>06/30/24-3 Readings:<br><br>10:59 105/63 mm/hg<br><br>12:24 107/63 mm/hg<br><br>17:46 95/54mm/hg *Diastolic Low of 60 Exceeded<br><br>07/01/24-2 Readings:<br><br>10:57 104/55 mm/hg *Diastolic Low of 60 Exceeded<br><br>18:29 113/80 mm/hg<br><br>07/02/24-1 Reading:<br><br>15:20 116/61mm/hg<br><br>07/03/24-2 Readings:<br><br>1:42 145/88 mm/hg *Systolic high of 139 exceeded<br><br>14:47 56/27 mm/hg *Systolic low of 90 exceeded, Diastolic Low of 60 exceeded.<br><br>Based on the physician order for vitals every four hours from 06/19/24 to 07/02/24 (Resident was transferred to the hospital on 07/03/24) there should have been a total of 84 blood pressure readings taken and the EMR reflected that only 28 blood pressure readings were taken.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 07/16/24 at 2:02 PM, the surveyor interviewed the Director of Nursing (DON) regarding if the facility administered Intravenous Therapy (IV). The DON stated that Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) do IV therapy and only RNs can administer Milrinone. The DON stated we had one resident on Milrinone and we had an in-service from someone from the pharmacy and the nurses had been educated. The DON stated we only took that admission during the week and the facility had to monitor their blood pressure. The DON stated, when one IV bag was finished, the other bag had to be ready to be administered. The surveyor asked if there was a policy related to the administration of Milrinone and the DON stated, most likely. The DON stated that Resident #88's Milrinone must be changed and checked by 2 RN's every four hours which was also confirmed by the Assistant Director of Nursing (ADON) who joined the interview. The ADON stated that every 4 hours the resident's blood pressure needed to be checked. The surveyor requested the blood pressure monitoring. The ADON, who was also the staff educator, stated there had to be 2 set ups and 2 bags of Milrinone ready at all times. The surveyor asked the ADON was the blood pressure checked every four hours and the surveyor requested a policy for checking the blood pressure every four hours.<br><br>The ADON stated it wasn't because of the milrinone (re: Resident #88) it was running. The surveyor asked if there was an investigation, and the ADON stated, no investigation. The ADON stated there are other parameters that needed to be watched, and the surveyor asked why, because [Resident #88] could die. The DON then brought in same parameter of blood pressure readings that the surveyor had already reviewed, and stated, I see what you mean regarding the blood pressures not being monitored 6 times per day. The ADON then provided the surveyor with information from the consultant pharmacy that the ADON stated staff were in-serviced on. The surveyor asked if all staff were in serviced and she stated, they should have been. The surveyor reviewed the document which revealed: Nursing assessment: Monitor heart rate and BP (blood pressure) continuously during administration. Slow or discontinue if BP drops excessively. Monitor intake and output and daily weight. Assess patient for resolution of signs and symptoms of HF (Heart Failure) (Peripheral edema, dyspnea, rales/crackles and weight gain) . Monitor ECG [Electrocardiogram) continuously during infusion. Arrythmias are common and may be life threatening . The surveyor asked the ADON about the required monitoring and the ADON stated that was for the hospital only.<br><br>On 07/17/24 at 10:58 AM, the surveyor conducted an interview with the Medical Director (MD) who was also Resident #88's physician. The surveyor asked the MD if they reviewed policies related to administering the Milrinone. The MD stated, I haven't really reviewed policies. The surveyor asked if there was a discussion regarding a policy and she stated, no, discussion. The MD stated she reviewed Resident #88's medication upon admission and that is when she found out that the resident was on Milrinone. The MD confirmed that she was not aware prior to admission. The MD stated she questioned the facility regarding how to handle the Milrinone and to make sure the correct monitoring was in place, and she spoke with the ADON. The MD stated she felt comfortable about the monitoring and she spoke with the cardiologist also. The MD stated the vitals, every 4 hours and weekly labs were specifically what needed to be monitored. The MD clarified the vitals to include blood pressure and heart rate, and full vitals and daily weights.<br><br>When asked about the facility policy on Milrinone administration, she stated, I don't know if they had a policy, they did not inform me of that.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 07/18/24 at 9:25 AM, the DON handed the surveyor a paper and stated it was the Milrinone policy because we didn't have one. The surveyor asked the DON if you should have had a policy regarding the administration of Milrinone before and she stated, no. The DON stated, you asked for a policy and we didn't have one, so I put one together.<br><br>b.) A review of the closed medical record revealed an Admission Record that Resident #296, was admitted to the facility with diagnoses which included but were not limited to; paroxysmal atrial fibrillation (type of irregular heartbeat, chronic obstructive pulmonary disease (COPD; constriction of the airways making it difficult or uncomfortable to breathe), hypercholesterolemia (high cholesterol), malignant neoplasm (cancerous tumor or cancer) and anxiety.<br><br>Review of the Admission Minimum Data Set (AMDS), an assessment tool used to facilitate the management of care, dated 5/4/24, reflected the resident's Brief Interview for Mental Status (BIMS) was not conducted since the resident was rarely/never understood. The resident did not exhibit behaviors associated with hallucination or delusions. Further review of the MDS revealed the resident was occasionally incontinent of bladder.<br><br>A review of the nurses' admission Progress Note (PN) dated 5/4/24 at 5:53 PM reflected late entry and indicated the resident arrived at 4:30 PM from the hospital via stretcher with a primary diagnosis of diarrhea. The resident was documented as alert and oriented to person only and was confused, forgetful and high risk for falls; the call bell was placed [at an undescribed location]. The resident was incontinent of bowel and bladder. The PN included that the resident was assisted to bed and the head of the bed was elevated. While in the facility, the resident was to continue receiving chemotherapy through a right port catheter on the upper right chest wall for the diagnosis of cancer that had spread to the bone.<br><br>The PN also included that the resident had numerous bruises to the upper and lower abdomen, an old skin tear to the arm, a scabbed area on the left heel, and redness to the sacrum wherein a protective barrier was applied and left open to air. The resident was receiving 5 liter of oxygen and a CPAP machine (continuous positive air pressure to keep breathing airways open) at bedtime. The medications were confirmed and verified by the physician.<br><br>A review of the electronic Medical Record did not reflect a baseline care plan was initiated for Resident #296.<br><br>A review of the resident's electronic Medication Administration Record included the following physician's orders that was marked x and was not documented as administered, unavailable, refused by the resident and/ or acted upon by the staff on the ordered date of 5/4/24.<br><br>1) Pacerone (Amiodarone), give 1 tablet by mouth two times a day, for antiarrhythmic, ordered on 5/4/24 at 9:14 PM. The eMAR was not opened for administration until 5/5/24 at 9:00 AM.<br><br>2) Advair (Fluticasone-Salmeterol) Discuss inhalation 250-50 milligram (mg), 2 puffs orally two times a day for shortness of breath, ordered on 5/4/24 at 10:11 PM. The eMAR was not opened for administration until 5/5/24 at 9:00 AM.<br><br>3) Dexamethasone 2 mg, give 1 tablet by mouth two times a day, for five days, ordered on 5/4/24 at 11:59 PM. The eMAR was not opened for administration until 5/5/24 at 9:00 AM.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4) Crestor 20 mg, give 1 tablet by mouth one time a day at bedtime for hyperlipidemia, ordered on 5/4/24 at 9:42 PM.<br><br>5) Short form pain assessment every shift, ordered on 5/4/24 at 11:11 PM. The eMAR was not opened for action/documentation until 5/5/24 for the day shift.<br><br>6) Vital every shift for 7 days, ordered on 5/4/24 at 11:11 PM. The eMAR was not opened for action/documentation until 5/5/24 for the day shift.<br><br>Further review of the eMAR also included and order for Dilaudid (Hydromorphone) 2 mg, give 1 tablet by mouth every 4 hours as needed for pain, give for severe pain scale of 7 to 10, ordered on 5/4/24 at 10:11 PM. The eMAR was opened for administration on 5/4/24. An order for mild to moderate pain was not reflected on the eMAR.<br><br>At that time, the DON stated that for a resident admitted on , or after 12:30 PM, the facility had back-up (emergency) medication supply available [limited to the facility's inventory formulary] or the facility could ask the physician for an alternative to the medication prescribed that was available in the facility. The medications ordered from the pharmacy arrived in the midnight delivery. The DON also stated that they were able to pick up prescriptions from [name redacted], a neighborhood pharmacy with whom they were also contracted through their pharmacy provider.<br><br>At that time, the DON stated that if the facility had the resident's medication in the back-up medication supply, then they would administer the medication to the resident. For physician orders placed after 4:30 PM the expectation was that the nurse would place a call to the physician and inform the physician that the dose would be missed and would not be administered until the next scheduled administration.<br><br>At that time, the surveyor and the DON reviewed the resident's PN together. The DON confirmed that the communication made by the nurse to the physician that allowed for a missed dose should have been documented in the progress notes and it was not. The DON acknowledged that since it was not documented, there was no evidence that the nurse had called the physician for the resident.<br><br>At that time, the surveyor and the DON reviewed the resident's eMAR together. The DON stated that the x meant that the orders were not opened for administration/action on the same date as the ordered date for the following: Amiodararone, Advair, Dexamethasone, Crestor, pain assessment and vitals.<br><br>On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the failure to acquire routine medications without delay, for timely administration, provide pain assessment and monitor for vitals on the ordered date by the physician for Residents #296.<br><br>On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 3.) A review of the closed medical record revealed an Admission Record that Resident #297 was admitted to the facility with diagnoses which included but were not limited to; malignant neoplasm of unspecified site of the breast, acute diastolic congestive heart failure (decreased contractility of the heart's pumping chamber, and the inability to fill with blood properly in between beats), presence of prosthetic heart valve, and acute respiratory failure with hypoxia (sudden onset of an inability to breath resulting in decreased levels of oxygen in the blood and to body tissue).<br><br>Review of the MDS dated [DATE], reflected the resident's Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident's cognition was intact . The resident did not exhibit behaviors associated with hallucination or delusions. Further review of the MDS revealed the resident required substantial/maximal assistance (helper does more than half the effort) for mobility such as rolling left and right, sit to lying, lying to sitting, sit to stand, chair/bed to chair transfer and toilet transfer.<br><br>A review of the nurses' admission PN dated 10/29/22 at 3:15 PM, indicated the resident arrived at 2:15 PM from the hospital via stretcher with a primary diagnosis of hematoma of the left breast. The resident was described as alert, oriented with vital within normal limits, no documented signs and symptoms of distress or pain. The documentation for medications confirmed and verified by was blank.<br><br>A review of the nurses' PN dated 10/29/22 at 9:12 PM reflected the medications and diet orders were confirmed and verified with the covering physician.<br><br>A review of the resident's electronic Medication Administration Record included an order for Magnesium Oxide oral tablet 400 milligram, give 1 tablet by mouth two times a day for electrolyte replacement, ordered on 10/29/22 at 6:55 PM and was marked x, and was not documented as administered, unavailable, or refused by the resident, or acted upon for the 5:00 PM scheduled administration.<br><br>On 7/17/24 at 11:17 AM, during an interview with two surveyors, the Director of Nursing (DON) explained the process of resident admission that began with her receipt of the resident's hospital record which she reviewed to assess if the facility had the ability to admit the resident.<br><br>After acceptance of the resident, the information is communicated with the admission department and the hospital, then the resident is admitted into the facility and was assessed upon arrival. The medication orders were verified with the physician, and electronically sent to the pharmacy provider.<br><br>At that time, the DON stated that for a resident admitted on , or after 12:30 PM, the facility had back-up (emergency) medication supply available [limited to the facility's inventory formulary] or the facility could ask the physician for an alternative to the medication prescribed that was available in the facility. The medications ordered from the pharmacy arrived in the midnight delivery. The DON also stated that they were able to pick up prescriptions from [name redacted], a neighborhood pharmacy with whom they were also contracted through their pharmacy provider.<br><br>At that time, the DON stated that if the facility had the resident's medication in the back-up medication supply, then they would administer the medication to the resident. For physician orders placed after 3:00 PM the expectation was that the nurse would place a call to the physician and inform the physician that the dose would be missed and would not be administered until the next scheduled administration.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | At that time, the surveyor and the DON reviewed the resident's PN together. The DON confirmed that the communication made by the nurse to the physician that allowed for a missed dose should have been documented in the progress notes and it was not. The DON acknowledged that since it was not documented, there was no evidence that the nurse had called the physician for the resident.<br><br>At that time, the surveyor and the DON reviewed the resident's eMAR together. The DON stated that the x meant that the order for Magnesium Oxide was not opened for administration on the same date as the order date of 10/29/22 at 6:55 PM and was instead opened for administration on 10/29/22 at 9:00 AM and at 5:00 PM.<br><br>At that time, in the presence of the surveyors, and the DON, the surveyor discussed the reviewed concerns for Resident #297.<br><br>On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the failure to acquire routine medications without delay, for timely administration to Resident #297.<br><br>On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns.<br><br>A review of the facility provided job description for the DON included the following:<br><br>Monitor medication passes and treatments schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled.<br><br>NJAC 8:39-27.1 (a) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>27193<br><br>Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate services for a resident with limited mobility who was discharged from Physical therapy to restorative services to prevent further decline in Range of motion. This deficient practice was identified for 1 of 2 residents (Resident #13) reviewed for a limited range of motion (ROM).<br><br>This deficient practice was evidenced by the following:<br><br>On 07/17/24 at 09:49 AM, the surveyor observed Resident #13 seated in the hallway of the A Wing, by the Television area. Resident #13 had some black and bluish discoloration on the chin, and both hands were contracted. There were no splints or hand rolls in use at that time. The Temporary Nurse Aide (TNA) who provided care to Resident #13 confirmed that Resident #13 could not open their hands, and there were no assistive devices in the room to apply on their hands.<br><br>On 07/17/24 at 10:08 AM, the surveyor inquired with the Assistant Director of Nursing (ADON), if the facility had a restorative program. The ADON stated that a Resident would be referred/ screened by Physical Therapy (PT) and when they do not meet the criteria for continuous therapy, they would be placed on the restorative program. The ADON attempted to open Resident #13's hands and was unable to fully open their hands.<br><br>On 07/17/24 at 10:11 AM, in the presence of the ADON, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager (LPN/UM) regarding the restorative program and the restorative book where the staff would document what had been done [services] for the residents. The LPN/UM stated that she used to assist Resident #13 with ambulation everyday, however, the restorative book had been missing for the last two months, and had no proof that the restorative program was functional.<br><br>On 07/17/24 at 10:30 AM, the ADON informed the surveyor that the Certified Nursing Assistants (CNAs) were responsible to do Range of Motion (ROM) during care. The ADON reviewed Resident #13's electronic medical record (emr) and could not locate an order for ambulation and any assistive devices used to prevent further decline in ROM.<br><br>On 07/17/24 at 11:05 AM, the LPN/UM confirmed that Resident #13 did not have any hand roll in the last 2 years. She further added that Resident #13 can hold the walker and ambulate with assistance. When asked for the documentation regarding Passive Range of Motion (PROM)/Active ROM (AROM) for Resident #13, she was unable to provide any documentation. The surveyor asked the LPN/UM what was the goal of restorative nursing. The LPN/UM stated that the goal was to prevent further decline. The LPN/UM also stated that Resident #13 had a fall, and that she was going to refer Resident #13 to PT but could not explain what had happened. The surveyor requested all documentation regarding the restorative nursing program for Resident #13.<br><br>A review of Resident #13's Admission Record, an admission summary, reflected that the resident was admitted to the facility with diagnoses that included arthropathy unspecified (disease of the joints), Parkinson's disease (progressive disorder that affects the nervous system), mood disturbance and hypotension (low blood pressure).<br><br>(continued on next page) |

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| | 315195 | A. Building<br>B. Wing | 07/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Autumn Lake Healthcare at Berkeley Heights | 35 Cottage Street<br>Berkeley Heights, NJ 07922 |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | A review of the Annual Minimum Data Set (AMDS), an assessment tool, with an Assessment Reference Date (ARD) of 5/5/24, reflected a brief interview for mental status (BIMs) score of 9 out of 15 which indicated that the resident's cognition was moderately impaired.<br><br>Further review of the AMDS under Section O.0500 Restorative Nursing Programs, revealed the number of calendar days passive range of motion, active range of motion and splint or brace assistance performed for at least 15 minutes a day in the last 7 calendar days, was coded zerowhich indicated none or less than 15 minutes daily was performed.<br><br>The surveyor reviewed Resident #13's Care Plan (CP) dated/revised on 03/18/22. The CP had a focus of Restorative Nursing Program (RNP) for sit to stand. This activity will be performed by the CNA when Resident #13 agreed to it. The goal reflected Resident #13 will maintain present level of functioning. Interventions included: Assess response to program and adjust as needed, initiated on 12/11/20. Provide restorative nursing program, initiated on 9/08/2021. Skilled therapy screen for skilled interventions as needed, initiated on 12/11/20.<br><br>A review of the nurse's Progress Note (PN) reflected Resident #13 had an unwitnessed fall on 7/13/24, and was not referred to therapy services for skilled interventions as indicated on the care plan.<br><br>On 07/17/24 at 12:07 PM, the surveyor interviewed the Physical Therapy Director (DPT). The surveyor inquired regarding the restorative nursing post discharge from PT. The DPT added that PT services always recommended restorative nursing post discharge to prevent decline. He added that the nursing department was in charge of restorative. The DPT further stated that Resident #13 had a palm protector at some point and that he would review the case. The DPT also added only residents on hospice were exempt from restorative nursing.<br><br>On 07/17/24 at 12:20 PM, the DPT provided the therapy screen and the discharge summary. A review of the PT Discharge Summary dated 05/06/23, indicated that Resident #13 had achieved maximum potential, and was to continue with restorative ambulation program. The order was as followed: Ambulation program established/ Trained: gait with rolling walker minimum assist of 1 [person] x 60 feet with wheelchair follow.<br><br>On 07/17/24 at 12:31 AM the surveyor met with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), and requested the policy for restorative and range of motion.<br><br>The surveyor reviewed the facility undated policy regarding Resident Mobility and Range of Motion provided by the corporate nurse. The policy indicated, Residents will not experience an avoidable reduction in range of motion(ROM). Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM.<br><br>Residents with limited range of motion will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.<br><br>Interventions may include therapies, the provision of necessary equipment, and/ or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Documentation of the resident's progress toward the goals and objectives will include attempts to address any change or decline in residents condition or need.<br><br>NJAC 8:39-27.1(a), 27.2(m) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>45449<br><br>Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident received oxygen as ordered for 1of 3 residents (Resident #243) reviewed for oxygen administration.<br><br>This deficient practice was evidenced by the following:<br><br>On 7/14/24 at 6:45 PM, the surveyor observed Resident #243 in bed, with the Oxygen (O2) concentrator (a medical device used for delivering oxygen) set between 2 and 2.5 liters per minute (LPM). The resident was awake and conversant.<br><br>On 7/15/24 at 12:25 PM, the surveyor observed the resident in bed, with the O2 concentrator set between 2 and 3 LPM. The resident was awake and conversant.<br><br>The surveyor reviewed the medical record for Resident #243.<br><br>According to the Admission Record, an admission summary, Resident #243 was admitted to the facility with diagnoses that included acute respiratory failure with hypoxia (low levels of O2 in body tissues, causing confusion, bluish skin, and changes in breathing and heart rate).<br><br>The Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 6/28/24, reflected a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident was cognitively intact.<br><br>A review of the active Order Summary Report for July 2024 included an order for O2 at 3 LPM continuous nasal cannula (to keep oxygen saturation (greater than) > 94% every shift for SOB (shortness of breath) or dyspnea (sensation of not being able to breath fast enough or deep enough).<br><br>A review of the ongoing Care Plan (CP) reflected a focus that included, the resident had difficulty breathing related to recent acute respiratory failure. The interventions included, provide oxygen as ordered, which was initiated on 6/14/24.<br><br>A review of the electronic Treatment Administration (eTAR) reflected an order for O2 inhalation to 3 LPM continuous nasal cannula (to keep oxygen saturation >94%) every shift for SOB/dyspnea ordered on 6/22/24. The eTAR reflected the nurses signed daily on every shift except for the following: on 7/2/24 for the evening shift, on 7/3/24 for the day shift and on 7/4/24 for the evening shift.<br><br>On 7/17/24 at 11:31 AM, the surveyor and the Licensed Practical Nurse (LPN) entered Resident #243's room, observed Resident #243's O2 concentrator was set to 2 LPM and exited the room. At that time, the LPN confirmed the O2 was set to 2 LPM.<br><br>On 7/17/24 at 11:33 AM, the surveyor and the LPN reviewed the electronic Medical Record (eMR) together which revealed the physician's order was for O2 at 3 LPM.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/17/24 at 11:35 AM, in the presence of the surveyor, the LPN informed the Registered Nurse/ Unit Manager. The RN/UM instructed the LPN to check Resident #243's blood oxygen level, call the physician, and that she would inform the Director of Nursing, the resident and family.<br><br>On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concerns regarding the failure to follow the physician's order for the O2 and to maintain the respiratory services for the resident.<br><br>On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns.<br><br>A review of the provided facility policy Oxygen Administration, dated/revised 10/23 included the following:<br><br>Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.<br><br>Policy Explanation and Compliance Guideline:<br><br>1. Oxygen is administered under orders of a physician .<br><br>NJAC 8:39-27.1(a) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>Based on observation, interviews and review of pertinent facility documents, it was determined that the facility failed to ensure Nurse Aides (NAs) received the required training and competencies needed prior to receiving their own assignment to provide direct resident care independently. This deficient practice was identified for 2 of 2 NAs (NA #1 and NA #2) who worked on 2 of 3 Nursing units and were enrolled in a Nurse Aide Training School on 06/18/2024.<br><br>The NAs failed to complete Module 2 of the NATCEP (Nurse Aide Training and Competency Evaluation Program) and there were no competencies provided by the facility to ensure training was adequate prior to receiving their own assignment. In addition, the facility had no record of the NAs having completed the required modules.<br><br>The two NAs rendered direct resident care which included, but was not limited to bathing, toileting, transferring, feeding, personal, hygiene and grooming. Both NAs were enrolled in a Nurse Aide Program on 06/18/24, completed Module 1 as of 07/12/24, and were assigned to provide independent direct care beginning on 7/5/24 and worked on 2 of 3 units.<br><br>This failure to ensure that the NAs received the required training with the appropriate competencies and completed Module 2 prior to receiving an independent resident care assignment placed all residents at risk for the likelihood that serious injury, harm, impairment, or death as non-certified staff were providing direct care to residents. This resulted in an Immediate Jeopardy (IJ) Situation.<br><br>The IJ began on 07/05/2024, when two NAs provided direct resident care without adequate training and competencies. The facility Administration was notified of the IJ on 07/19/24 at 12:30 PM. The facility submitted an acceptable Removal Plan (RP) on 07/19/2024 at 2:07 PM. The Removal Plan indicated the action the facility will take to prevent serious harm form occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including:<br><br>- Corrective Action: All Nurses' Aide (NA) were immediately removed from the schedule, off patient care and no longer employed by the facility.<br><br>- Identification of At-Risk Residents: All residents residing in the facility have the potential to be affected by the deficient practice.<br><br>- Systemic Change: The Regional Director of Nursing in-serviced the Human Resources Director, Director of Nursing, staffing coordinator and Administrator, that the facility will no longer hire Nurse's Aide (NA) or any unlicensed personnel.<br><br>- Quality Assurance: The director of Nursing /designee will review the nursing schedule with the staffing coordinator to ensure Nurses' Aide or non-license personnel are not on the schedule. Any findings will be addressed immediately and reported to the administrator as well as the Quality Assurance Committee quarterly for six months or until compliance is met.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 07/19/24 and the IJ was removed.<br><br>The evidence was as follows:<br><br>On 07/14/24 at 7:44 PM, during the entrance conference with the Director of Nursing (DON), in the presence of the survey team, the surveyor asked the DON if the facility utilized non-certified Nurse Aides (NAs). The DON stated, yes we do, and stated that the NAs went to school for two weeks and then they were permitted to provide direct resident care. The DON stated she will provide the NA list tomorrow.<br><br>On 07/15/24 at 10:50 AM, the Human Resources Director (HRD) provided the surveyor with a copy of an email and attached documents from the Vocational School Regional Operation Director (VSROD) dated Friday, July 12, 2024, at 3:09 PM.<br><br>The surveyor reviewed the email with the attached documents which revealed Subject: Compliance Request. Compliance has flagged the following: Missing PPD 2/TB Clearance 1 for [NA name redacted]; Missing Covid test [4 NA names redacted]; Missing Physical [1 NA name redacted]. The surveyor asked the HRD about the program and she stated it was her program, she developed since the facility needed more staff. The surveyor asked what the NAs job function was and the HRD stated the NAs helped feed, get residents out of bed, and transferred residents.<br><br>An attached letter dated the same date, 07/12/24, revealed: Re: [NAME] Lake Sponsor Status Update, please note within your status update for currently sponsored students:<br><br>1. Course: Certified Nursing Assistant Course<br><br>2. Campus (school address)<br><br>3. Start Date: June 18th, 2024<br><br>4. Students:<br><br>NA #1: GPA 93.6% (MODULE-1 COMPLETED)<br><br>NA #2: GPA: 78.3% (MODULE-1 COMPLETED)<br><br>NA #3: GPA: 75% (MODULE-1 COMPLETED)<br><br>The surveyor requested the employee files for the three (3) NAs, which were provided by the HRD and revealed the following:<br><br>- NA #1 - Hired 04/23/24 as a Hospitality Aide and transitioned to an NA on 07/03/24.<br><br>- NA #2- Hired on 05/15/24 as a Hospitality Aide and transitioned to an NA on 07/03/24.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 7/16/24 at 8:41 AM, the surveyor interviewed the HRD and requested all the information for the NAs. The surveyor reviewed the nurse staffing assignment sheets from 4/22/24 to present to review the NAs schedules which revealed the following resident assignments:<br><br>- On 07/05/24, during the 7:00 AM- 3:00 PM shift, NA #1 was assigned nine (9) residents on the B wing, including three (3) residents who required a shower; NA #2 was assigned eight (8) residents on the A- Wing.<br><br>- On 07/06/24, during the 7:00 AM- 3:00 PM shift, NA #1 was assigned nine (9) residents on the B-Wing.<br><br>- On 07/07/24, during the 7:00 AM- 3:00 PM shift, NA #1 was assigned nine (9) residents on the B-Wing and NA #2 was assigned eight (8) residents on A- Wing.<br><br>- On 07/08/24, during the 7:00 AM- 3:00 PM shift, NA #1 was assigned nine (9) residents on the B-Wing and NA #2 was assigned eight (8) residents on the A- Wing.<br><br>- On 07/10/24, during the 7:00 AM- 3:00 PM shift, NA #2 was assigned eight (8) residents on the A Wing.<br><br>- On 07/12/24, during the 7:00 AM- 3:00 PM shift, NA #1 was assigned 10 residents and three (3) residents required a shower; NA #2 was assigned 10 residents on the A Wing and both on B-Wing<br><br>- On 07/13/24, during the 7:00 AM- 3:00 PM shift, NA #2 was assigned seven (7) residents on the A Wing.<br><br>The surveyor continued to interview the HRD regarding why the NAs were listed on the staffing sheets and listed with assignments. The HRD stated they were working as hospitality aides. The HRD stated they only give ice, transport residents, and answer call bells.<br><br>On 07/16/24 at 10:45 AM, during a follow up interview with the HRD. The surveyor asked what the NAs were responsible for. The HRD stated, they don't do anything but give water, they don't have an assignment. The HRD stated they were Hospitality Aides when the NAs were in school. The surveyor asked about training and when the NAs could have their own assignment and were able to provide direct resident care independently. The HRD stated, I was told two weeks, and the surveyor asked by whom? The HRD stated, a lady I talked to in the state, however, the school told me that after two weeks the NAs could have their own assignment and they could work with someone. She stated she would review the module.<br><br>On that same date and time, the surveyor asked what modules needed to be completed before providing independent direct resident care. The surveyor also asked if the training school had provided a certificate of completion to the facility for the NAs or any other document besides the email and the HRD stated no. The surveyor requested the policies for the NA program and Hospitality Aide Program.<br><br>On 07/16/24 at 10:55 AM, the HRD provided the surveyor with a blank Concierge Job Description which she indicated was the Hospitality Aide Job description and a copy of the Department of Health (DOH) Nurse Aide Examination Bulletin.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 07/16/24 at 11:00 AM, the surveyor conducted a telephone interview with the VSROD regarding the Nurse Aide training. The VSROD stated, we are a state approved vocational school and we have ten schools in the state. The VSROD stated the email provided to the facility was for a compliance check for the employees. The surveyor asked the VSROD if they provided the facility with the nurse aide program. The VSROD stated, we have nothing to do with the facility's internal policy and procedures. The surveyor asked the VSROD if he was aware of how the facility should be hiring the NAs and he stated, we are not privileged to anything that should be done. The surveyor asked what documentation and communication was provided to the facility regarding the NA education. The VSROD stated, we give updates as requested and give final documents as approval.<br><br>On 07/16/24 at 11:35 AM, the HRD provided the Nurse Aide Qualifications and Training Requirement Policy Statement which revealed the following:<br><br>Our facility will not use any individual as a nurse aide who has worked less than four months unless the individual is a full-time employee and participation in a state approved training and competency evaluation program; or has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program; or has been determined competent as provided in 483.150(a) and (b) of the Requirements of Participation.<br><br>At that same time, the HRD stated all staff can be scheduled to work independently after passing Module 1.<br><br>On 07/18/24 at 9:58 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the survey team was asked what was the NA process. The LNHA stated that the idea was that we have a course. The LNHA stated, I don't know how many hours they are in the course to become CNA's and until a certain amount of time passes, they can work, I'll find out. The surveyor asked what the facility policy was to ensure the NAs received the required training and competencies prior to receiving their own assignments and providing direct resident care independently. The LNHA stated, I will let you know.<br><br>On 07/18/24 at 10:19 AM, during a follow up interview with the LNHA. The LNHA stated he was not sure what the surveyor needed. The surveyor asked who was responsible for overseeing the NAs at the facility. The LNHA stated, the HRD. The surveyor asked what information was needed regarding the NAs that would allow them to work independently and he stated he would find out.<br><br>On 07/18/24 at 10:43 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that after the NAs completed 16 hours of training they were paired with a CNA. When the CNA feels the NA was ready, the Assistant Director of Nursing (ADON) would let her know when the NAs were okay to be assigned with their own assignment.<br><br>On 07/18/24 at 11:45 AM, in the presence of the survey team, the LNHA stated, there is a 16-hour course the NAs take, I will give you the policy and they spend at least 10 days with a preceptor and they take a competency exam and they can work alone. The LNHA did not provide any information regarding when the NAs passed Module 2.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 07/18/24 at 12:13 PM, the surveyor interviewed the ADON who was also the staff educator. The surveyor asked when were the NAs permitted to work independently. The ADON stated that the NAs were hired as Hospitality Aides (HA) and she had been told that the current NAs all passed Module 2. The surveyor showed the ADON the email documenting that the NAs passed module 1 as of 7/12/24. The ADON confirmed that the NAs were scheduled with full assignments after passing module 1 only, but she was told by the HRD that they passed module 2. The ADON stated she had no idea that the NAs only completed Module #1. The ADON further stated the NAs haven't completed the course yet and they shadowed someone for 16 hours. The ADON confirmed that the NAs must complete module 1 and 2 prior to having an independent resident care assignment and stated that it was not her responsibility to make sure that the NAs completed module 2. She stated, I only go by what they told me, the HRD handles the school part.<br><br>On that same day, the surveyor reviewed the CNA Orientation Clinical Competencies Sheet that was used for the NAs. The surveyor asked what the process was as the Skills were identified and there was an initial by the NA and the Validator. The surveyor asked if there was an actual competency process in addition to the checklist. The ADON confirmed there was not.<br><br>On 07/18/24 at 12:33 PM, during a follow up interview with the HRD, the surveyor asked if the NAs were scheduled to provide independent direct resident care prior to completing module 2. The HRD stated, I never told them module 2 and confirmed that the NAs had assignments prior to that. The HRD stated, moving forward I will make sure the NAs complete their modules. The HRD further stated the CNA school only sent emails when the NAs completed Module 1, and the VSROD told her that after 16 hours the NAs can be with someone on the floor. She stated, as far as I know, I thought they were paired with someone and I thought they were paired with someone for two weeks until they were comfortable.<br><br>During that same interview, the surveyor asked how would nursing know that they can schedule NAs independently? The HRD stated, I guess if they feel comfortable and they do their competencies. The HRD stated, I dropped the ball and I didn't know when the NAs finished their modules. The HRD stated, I just put the program together, I don't have any oversight.<br><br>On 07/19/24 at 8:41 AM, the surveyor interviewed NA #2 who was working on the unit and assigned a full resident assignment and was observed leaving a resident room with a bag of soiled incontinence briefs. NA #2 stated she changed a resident and would speak with surveyor. The surveyor asked if she was a CNA and NA #2 stated, not yet, not certified yet. When asked when she started working, she stated on May 14th or 15th. She stated she was hired as a HA and answered call bells and I feed them. The surveyor asked about an orientation and she stated, that the HRD asked her how many days she thought she needed and I said three. The facility picked a CNA, they were [rendering care to] patients and I watched them. When asked about receiving an independent assignment, NA #2 stated it was the week of July 1, 2024, and that was when she started module 1 at school.<br><br>At that time, NA #2 showed the surveyor her mobile phone with an APP (an application downloaded to a mobile device) with her grades and she said she took her Module 1 test on 07/02/2024, and passed it. The surveyor asked about Module 2 and NA #2 stated she took the test on July 9th, and she failed the test because she needed 75% and she only got 71% and she showed the surveyor the score on her phone. NA #2 stated, I did not pass that, and she re-took the test on 07/16/24, and she still did not know if she passed it. NA #2 stated she did not know about the passing grade but the school started on Module 3.<br><br>(continued on next page) |

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| | 315195 | A. Building<br>B. Wing | 07/19/2024 |

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| Autumn Lake Healthcare at Berkeley Heights | 35 Cottage Street<br>Berkeley Heights, NJ 07922 |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | The interview continued and the surveyor asked NA #2 if she used the mechanical lift and she stated that she was the second person when needed but doesn't have mechanical lifts on her assignment presently. NA #2 stated she helped toilet her residents and feeds them.<br><br>On 07/19/24 at 9:23 AM, the surveyor interviewed NA #1. He stated he currently had a full assignment and did not work in a health care field. NA #1 stated he started at the facility May 20, 2024, and on June 25, 2024, he started the CNA class and July 5th 2024, he had an orientation where he watched a CNA provide care. The ADON told him he would have three days orientation and then someone called out the third day and the ADON stated, congratulations, you are on your own and had a full assignment ever since. The surveyor asked if he felt comfortable providing care, and NA #1 stated, not really. NA #1 stated, for example, the resident in room [ROOM NUMBER] required lots of care, and had a catheter. NA #1 stated, no one taught me how to care for a patient with a catheter, how to empty the catheter, how to attach it to the leg, I am learning as I go, I asked questions. NA #1 further stated, he completed Module 1 on 07/01/2024, and started Module 2 on 07/09/2024 or 07/11/2024. He stated he was not comfortable providing resident care independently, and never went through a (skill) checklist. NA #1 stated he doesn't get report from the CNA's or the nurses.<br><br>On 07/19/24 at 1:09 PM, during an interview with the LNHA, the surveyor asked who was responsible for the NA program. The LNHA stated, he was aware of it but he did not oversee it.<br><br>N.J.A.C. 8:39-43.1 (a), 43.2(a)(b) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>45449<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the posted Nursing Home Staffing Report (24-hour staffing report) was up to date and provided accurate information.<br><br>This deficient practice was evidenced by the following:<br><br>On 7/14/24 at 6:05 PM, the surveyors entered the facility and observed the posted nursing home [24-hour] staffing report (NHSR) dated 7/12/24, in a plastic covered frame, on a table next to the entrance. The NHSR reflected that the current resident census (total number of residents) of 101. The posting indicated the number of registered nurses, licensed nursing staff and certified nursing staff on a shift. The shift and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care. The staffing report was not up to date and was two days late.<br><br>On 7/14/24 at 7:44 PM, during the entrance conference meeting, the Director of Nursing informed the surveyor that the census was 97.<br><br>On 7/15/24 at 9:13 AM, the surveyor observed the NHSR posted was dated 7/12/24. The staffing report was not up to date and was three days late.<br><br>On 7/15/24 at 9:17 AM, in the presence of the survey team, the Human Resources Director (HRD) stated that the receptionist was responsible for posting the NHSR daily, and the receptionist did not print out the report on the weekend. The HRD confirmed that the Monday NHSR was also not posted since she was still working on it, at that time.<br><br>At that time, the HRD informed the surveyors that the NHSR was posted after the morning meeting which occurred after 10:00 AM. The HRD acknowledged that the posting of the NHSR should have been up to date for the benefit of the residents, and their families or patient representative. Family and residents should know how many staff should be in the building.<br><br>On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concerns regarding the failure to post an up to date and accurate NHSR.<br><br>On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns.<br><br>A review of the provided facility policy, Staffing dated/revised on 2/23, did not include a process or procedure to address the requirement to post an accurate and up to date report.<br><br>N.J.A.C. 8:39-41.2 (a)(b)(c) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>45449<br><br>Refer 684 F<br><br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to acquire routine medications without delay, for timely administration to Resident #245. This deficient practice was identified during the medication administration observation for one (1) of two (2) nurses, who administered medications to four (4) residents (Resident #245).<br><br>The evidence was as follows:<br><br>On 7/16/24 at 10:16 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medications for Resident #245 that included a physician's order for Cholecalciferol oral tablet 10 microgram (mcg; 400 unit), give 1 tablet one time a day for supplement, started on 6/20/24. At that time the LPN stated that she did not have the medication in stock for administration. The LPN and the surveyor proceeded to review the order audit report which revealed a pharmacy supply order was created on 6/20/24 at 8:33 PM, for Resident #245's Cholecalciferol 10 mcg (400 unit) and reflected not received.<br><br>At that time, the LPN stated, it looks like it never came in, and confirmed that the order audit report did not reflect a received date.<br><br>A review of the June 2024, electronic Medication Administration Record (eMAR) reflected that the Cholecalciferol 10 mcg (400 unit) was documented as administered on 6/21/24 at 9:00 AM and from 6/23/24 through 6/30/24 at 9:00 AM. The eMAR on 6/22/24 at 9:00 AM was documented with a number 9, which indicated, to refer to the nurses' Progress Notes (PN). The PN for 6/22/24 at 9:00 AM revealed the facility was awaiting delivery.<br><br>A review of the July 2024, eMAR reflected that the Cholecalciferol 10 mcg (400 unit) was documented as administered from 7/1/24 to 7/15/24.<br><br>On 7/16/24 at 10:46 AM, in the presence of the Assistant Director of Nursing (ADON) and the surveyor, the Registered Nurse/Unit Manager (RN/UM) stated that when a medication was out of stock, the nurse on the medication cart can either order directly through the electronic Medication Record (eMR), call or fax the pharmacy. The RN/UM also stated that if a medication was not sent by the pharmacy provider, then we reach out.<br><br>At that time, the ADON stated that the expectation was that as soon as the nurse noticed during medication administration that there was an issue, the supervisor on duty should have been informed, the nurse should have checked with the pharmacy, and informed the doctor.<br><br>At that time, the RN/UM confirmed she was not informed that Resident #245's Cholecalciferol was not received from the pharmacy since 6/20/24.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At that time, the ADON confirmed that a stat immediate order was a service that the pharmacy provided.<br><br>At that time, the ADON also stated that if the medication was not available that a call should have been made to inform the prescriber.<br><br>On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the failure to acquire routine medication(s) without delay, for timely administration to Residents #245.<br><br>On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns.<br><br>A review of the facility provided job description for the DON included the following:<br><br>Monitor medication passes and treatments schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled.<br><br>NJAC 8:39-27.1 (a) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>45449<br><br>Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) provision of a permanently affixed compartment for storage of controlled dangerous substance (narcotic medications, with high potential for abuse and are tracked with detail) within the refrigerator, b.) drugs were labeled in accordance with acceptable pharmaceutical standards. This deficient practice was observed in one (1) of two (2) medication rooms, and one (1) of five (5) medication carts inspected during the medication storage and labeling task.<br><br>The evidence was as follows:<br><br>1.) On 7/14/23 at 7:52 PM, during a meeting with the survey team and the Director of Nursing, the surveyor requested for the policy for Medication Storage.<br><br>On 7/17/24 at 10:06 AM, in the presence of the Registered Nurse (RN), the surveyor began the refrigerator inspection located in the medication room B/Front. At that time, the RN and the surveyor observed the narcotic box was not affixed/not bolted, had a sticky white glue-like substance underneath, and was easily removed from the refrigerator. The narcotic box contained Resident #29's sealed narcotic medication, Lorazepam 2 milligram/ 1 milliliter.<br><br>At that time, the RN stated she would inform the Registered Nurse/Unit Manager. The RN also stated that the narcotic box should have been affixed/bolted for safety, so they can't just take it, steal it, or consume it. The RN acknowledged it was to prevent diversion.<br><br>2.) On 7/17/24 at 10:52 AM, in the presence of the Licensed Practical Nurse (LPN), the surveyor began the unit inspection of the 3A treatment cart. At that time, the LPN and the surveyor observed the drawers were divided into three compartments. The contents of the compartments had intermingled, opened prescription ointments, cream, and powder, and over the counter (OTC) medications. At that time, the LPN confirmed that the OTC medications were house stocked and was used for anybody.<br><br>At that time, The LPN and the surveyor observed the house stock medications intermingled with an opened, uncapped, unlabeled prescription medication, that had white creamy seepage along the side of the Mupirocin Ointment tube (antibiotic ointment).<br><br>At that time, the LPN stated that the prescription ointment/cream tubes should have been separated in its own bag, separated by residents, separated by indication, to avoid cross contamination. At that time, the LPN stated she would separate the medications. The LPN confirmed that the pharmacy provider had sent the topical prescription medications in separate bags and stated it should have been maintained that way. At that time, the LPN could not explain the reason for the unlabeled Mupirocin Ointment within the active inventory.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/17/24 at 11:05 AM, during an interview with the surveyor, the LPN/ Unit Manager (LPN/UM) confirmed that each resident's topical medication should have been maintained in separate bags and all prescription medications should have a prescription label. At that time, the LPN/UM stated she would destroy the contaminated topical medications, reorder, and inform the Assistant Director of Nursing (ADON), and the Director of Nursing (DON) of the concern.<br><br>On 7/19/24 at 1:48 PM, in the presence of the survey team, the corporate nurse, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concerns regarding the narcotic compartment in the refrigerator that was not affixed, and the intermingled opened, undated, undated prescription ointment intermingled with OTC medications.<br><br>On 7/19/24 at 2:15 PM, during a meeting with the survey team, the corporate nurse, the DON and the LNHA did not present further information regarding the discussed concerns.<br><br>A review of the provided facility policy, Medication Orders and Receipt Record, dated/revised on 8/23 included the following under Policy Interpretation and Implementation. The medication order/receipt shall contain: The prescription number; Resident's name .<br><br>No additional information was provided.<br><br>NJAC 8:39-29.4(a),29.7(c) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654<br><br>Based on observation, interview and document review, the facility failed to maintain the kitchen in a clean and sanitary manner to prevent the potential spread of food borne illness by failing to ensure: a) all foods were labeled with a use by date, foods were appropriately stored, and discarded after the expiration date, b) the environment, including the main kitchen, storage areas, and kitchen equipment were maintained in a clean and sanitary manner, and c) staff washed dishes in a clean and sanitary manner. The deficient practice was evidenced by the following:<br><br>On [DATE] at 6:13 PM, the surveyor began the kitchen tour with the Food Service Supervisor (FSS) and observed the following:<br><br>-One food service staff (FS )was washing dishes using the single tank dish machine, the FS used bare hands, placed in dirty dishes, removed the clean dishes without first performing hand hygiene and placed the clean dishes in the clean area.<br><br>- At that time, the surveyor then observed the FS stacking the burgundy lids on top of one another in a flat rack. The surveyor asked the FSS about the FS who touched the dirty dishes then the clean dishes without performing hand hygiene in between. The FSS stated, she was not supposed to do that.<br><br>-The dish machine temperature log was on the wall next to the dish machine; the surveyor asked the FSS what the temperatures should be. The FSS stated he does not know what temperatures for dish machine were. Both looked at the log hanging on the wall,which had the last documented temperature on [DATE] [the previous day]. The surveyor then asked how he would know if there was problem with the machine, if he did not know the temperature. The FSS stated the dish machine company came one time per week to check it.<br><br>-A large opened cottage cheese container, in the walk in refrigerator, was labeled, use by [DATE]rd. The FSS stated, it is expired.<br><br>- Frozen processed riblet item, was in the freezer, opened, and was not labeled with a use by date. The FSS stated, that she used it yesterday, then she walked over to a wall, that had a wall sheet, pulled a label with a date, and stuck it on the package.<br><br>-Bread crumbs in a package, was stored in a box, with other wrapped up opened food items, and the portable food service equipment that was not in use, had no opened date or use by date.<br><br>-The corner of the kitchen had several metal pans inside of one another, bread pieces were in one of the pans, the pasta was wrapped up, on top of the bread. Debris (various particles such as dust, crumbs, and dirt) was on the floor, a plunger on the bottom part of the metal table. In the same area, next to, and below had debris, and a dead insect on the floor.<br><br>-The prep sink in that area had the water running. The surveyor asked the FSS about it, he tried to turn it off, and was unable. The FSS stated, the plumber need to come.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - A large white tub of beef base (concentrated paste used as a food flavor enhancer) was on the table, not sealed. The table was visibly soiled.<br><br>-The area beneath the food preparation tables were soiled with varied debris, crumbs, etc. The FSS stated, I cleaned it Tuesday [it was Sunday]. The surveyor asked the FSS about the cleaning schedules for the kitchen, and the FSS stated, there was none.<br><br>- The can opener in the back area had debris, and the insert was stuck to the base.<br><br>-A red scoop was stored on top of thickener container, that was on the bottom of the table shelf, and not protected. There were visible debris throughout the container and on the table. The container next to it, had a white substance, not labeled, and visible debris. Both containers did not have a use by date.<br><br>-The hood above the stove appeared shiny, with caked on grease. The wall behind the entire cooking battery was soiled with visible splatters on the tile. The surveyor asked when it was cleaned and the FSS stated every six months, last time was January and it is time for that now.<br><br>-On [DATE] at 6:49 PM, the Human Resources Director, (HRD) arrived, joined the tour, and the surveyor showed her the debris. The HRD stated that once per week, we clean the whole kitchen, and randomly at end of day. The surveyor inquired about a cleaning schedule. The HRD stated every Tuesday we clean as needed.<br><br>-The dry storage room had debris throughout the floor, and underneath the last shelving above the floor were multiple packages of graham crackers. The surveyor asked the FSS about the storage areas, and the FSS, stated we do our cleaning on Tuesday. The surveyor asked the HRD if the area was clean and the HRD stated, no.<br><br>-The metal table by the ice machine had a sticky debris on it.<br><br>- ,d+[DATE] used personal beverage was located in milk box.<br><br>- Can opener in adjacent to the ice machine had dark debris on the insert.<br><br>-The Ice machine baffle had pinkish debris.<br><br>The Food Receiving and Storage Policy, updated [DATE], revealed:<br><br>Food Services, or other designated staff, will always maintain clean food storage areas. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated, dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in-first out system.<br><br>8:,d+[DATE].2(g) |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193<br><br>Based on observation, interview, record review, and review of pertinent facility documentation it was identified that the facility failed to identify and implement interventions to address resident concerns regarding staffing issues, staff training, grievances, abuse, issues with medications incontinence care, staff competency and the use of uncertified nurse aides, through their Quality Assurance and Performance Improvement program (QAPI). This deficient practice was identified on all 4 residents care units and was evidenced by the following:<br><br>Refer to: 558F, 600G, 610F, 677F, 684F, 688F, 728L<br><br>On 07/14/24 during a care tour, the surveyors observed that several of the resident's were left soiled in their excrement for an extended period of time. Residents observed with 2 and 3 incontinent briefs which were soaked with urine. Residents with Fingernails long jagged and soiled. Interviews with awake and alert residents revealed that the facility was short handed, and staff were not trained properly to care for the residents. One resident who was awake and alert, told the surveyor that they expressed their concerns regarding the lack of training to the Liscensed Nursing Home Administrator (LNHA) and nothing had been done.<br><br>As part of the facility protocol, the residents met monthly for the resident council meeting for the opportunity to voice their concerns. On 07/16/24 at 10:48 AM, a surveyor conducted the Resident Council Meeting with 11 awake and alert residents. During the meeting, 8 of 11 residents in attendance expressed concerns over staffing and staff incompetence.<br><br>The residents voiced concerns included statements such as, The CNAs were mostly agency staff, and they do not seemed to know the process. It is like they were never trained to care for residents. They have Zero vocabulary, they do not know how to speak to the residents. They will be in the hallway speaking a foreign language or being on the phone while providing care. They do not provide incontinence care in a timely manner and, the 3:00 PM to 11:00 PM staff were late for work and they do not provide incontinence care until bedtime. The 3:00 PM-11:00 PM staff were never available to provide incontinence care and other residents can notice the malodorous odor of urine and feces in the hallway. Staff has attitude and makes faces, [NAME] and puff when they have to assist. they do not know how to communicate. Concerns over the lack of communication among care givers. For example some residents had a diagnosis of dementia, and the staff were not trained to care for the residents due to lack of training. All the 11 residents who attended the resident council meeting would like to see improvement in communication, staffing, training and staff's attitude.<br><br>The surveyor requested the QAPI attendance log and the issues addressed during the QAPI Meeting for one year. The Director of Nursing provided the attendance log dated 10/12/23, 1/9/24, and 4/9/24. A hand written document dated 4/9/24 indicated the following issues: Ongoing call bell issues, staffing the main issue due to Certified Nursing Assistant not attending classes or failed out. Analysis of surrounding roles to be reviewed by Human Resources and staffing coordinator. Staff Managers -QAPI. Issues to be discussed and more participation requested -DON distributed forms and explained process.<br><br>5/31/24 No other QAPI. Parameter check ongoing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315195 | A. Building<br>B. Wing | 07/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Berkeley Heights | 35 Cottage Street<br>Berkeley Heights, NJ 07922 |

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 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Staffing increased using agency.<br><br>On 07/19/24 at 12:40 PM, the surveyor met with the DON and the Licensed Nursing Home Administrator (LNHA) regarding their QAPI Program. The LNHA stated that the facility met monthly with all department heads and reviewed the concerns. He stated that the last meeting was held on 4/9/24. The DON informed the surveyor that they were working on medication administration with parameters, weight loss staffing, kitchen sanitation.<br><br>The surveyor then asked the LNHA if he was involved in reviewing significant events, reportable events. The LNHA replied, no but going forward the facility will. Besides staffing, there were none of the issues identified during the survey addressed in the QAPI. The LNHA confirmed there was no data driven QAPI programs for the concerns identified with incontinence care, staff training, restorative care and grievances.<br><br>A review of the facility's Quality Assurance and Performance Improvement Program- Design and Scope updated April 2021 included that the facility QAPI Program is ongoing, comprehensive and addresses all care and services provided by the facility. The scope of our performance improvement efforts is reflective of the complexity of services and resources of the organization.<br><br>Policy Interpretation and implementation:<br><br>The QAPI program is designed to address all systems and practices in this facility that affects residents, including care, quality of life, resident choice and safety.<br><br>NJAC 8:39-33.1 (e); 33.2 (c) |

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|---|---|
| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>39399<br><br>Repeat deficiency<br><br>Based on facility staff interviews and review of pertinent facility documentation on 7/17/2024, it was determined that the facility failed to provide a designated qualified Infection Prevention and Control Nurse. This deficient practice is evidenced by the following:<br><br>During an interview with the facility's Infection Preventionist (IP) on 7/17/24 at 12:04 PM, she stated that she had performed both role as facility's IP and Assistant Director of Nursing (ADON) since 2019 and that she is the only IP Control Nurse in the facility at this time.<br><br>The ADON further stated that she is working full time as the ADON and the IP. She stated that on November 25th, 2020, she completed her Centers for Disease Control and Prevention training, receiving her certification as a Nursing Home Infection Preventionist.<br><br>During the Entrance Conference on 7/14/24 at 7:46 PM, the facility's Director of Nursing (DON) confirmed to the surveyor that the facility was licensed for 130 beds.<br><br>Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following:<br><br>ii. Required Core Practices for Infection Prevention and Control:<br><br>Facilities with 100 or more beds must hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to the hiring no later than August 10, 2021.<br><br>On 7/18/24 at 12:44 PM, the above concern was discussed to the DON who agreed that the IP must not have any other role. No further information was provided.<br><br>NJAC 8.39-20.2 |