STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315196	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Manchester	1770 Tobias Avenue Manchester, NJ 08759

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ 169435 Based on interviews, record review, and review of other facility documentation, it was determined that the facility failed to ensure the development of an individualized resident-centered care plan for a resident with documented behaviors toward residents and staff. This deficient practice was identified for 1 of 29 residents reviewed for the development of individualized care plans (Resident # 234). The evidence was as follows: On 04/16/24 at 10:00 AM, the surveyor reviewed the medical record for Resident #234. A review of the Admission face sheet record (an admission summary), reflected that the resident was admitted to the facility with diagnoses which included schizo-affective disorder, depression, and dementia with behavioral disturbance. A review of the Quarterly Minimum Data Set (MDS) dated [DATE], an assessment tool used to facilitate the management of care, reflected that the resident had severe cognitive impairment for daily decision making and had difficulty communicating with others. A review of the progress notes dated 09/14/23, reflected that Resident #234 had episodes of resisting care and increased frustration, restlessness. According to an entry dated 09/30/23, Resident #234 was sent out for psychiatric evaluation due to aggressive behavior toward another resident, threatening staff and agitation. A Note Text dated 09/30/23 and timed at 9:45 AM, revealed that staff heard a resident yelling in the hallway and observed Resident #234 standing in the doorway of another resident's room with his/her arms raised in the air and was yelling at the other resident. Staff slowly approached the resident to redirect him/her away from the other resident. Resident #234 balled the fists up and lunged at the staff. Resident #234 was sent out to the hospital. Review of the psychiatric assessment/evaluation form dated 09/30/23, reflected the following: Per staff on 9/30/23, pt [patient] was agitated, yelling, verbally aggressive towards others, labile, & impulsive . history of harm to others. Pt sent out for Evaluation on 9/30/23. Resident was sent to a Behavioral health facility (name redacted). Olanzapine (an antipsychotic) 2.5 mg (milligram) x 3 daily and Ativan 0.5 mg Q [every] 6 hours as needed was started at the Behavioral Health. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Another entry dated 10/03/23, revealed that Resident #234 was sent out to be evaluated due to increased agitation. Resident #234 was admitted for worsening dementia and returned to the facility on [DATE]. According to an entry in the clinical record dated 10/02/23, the resident was last seen by the psychiatrist on 10/02/23 with a new order to increase Depakote (a mood stabilizer) 375 mg at bedtime, Depakote sprinkles 250 mg in the morning and at 2:00 PM and to obtain the Depakote [blood] level on 10/09/23. Another psychiatric assessment dated [DATE], revealed the following: Seen for f/u [follow up] as per staff request due to recent incident. On 01/29/23 patient was agitated and grabbed another resident by the right arm, currently 1:1 [one to one observation]. Pt was sent out on 11/29/23 for an evaluation and returned to the facility on [DATE]. A review of the resident's individualized care plan dated 08/06/23, failed to address Resident #234's aggressive behavior toward staff and other residents prior to 11/30/23. The facility indicated that Resident #234 was placed on 1:1 observation. Review of the 1:1 observation log provided by the facility revealed that Resident #234 was on 1:1 observation prior to 11/30/23. However, the 1:1 observation log did not document the behavior exhibited. On 11/29/23, Resident #234 assaulted another resident around 8:30 PM causing pain to the right arm. X-Ray results revealed soft tissue injury to the right arm. The other resident had to be medicated for pain with Tylenol (a pain releiving medication). The behavior was not documented on the 1:1 observation log. The facility did not provide documentation to indicate how Resident #234 was able to make contact with the other resident while on a 1:1 observation. Further review of the resident's care plan revealed a focus area dated 11/17/23, for a mood problem related to anxiety, depression dementia and psychosis. The interventions included to provide the resident with a program of activities that is meaningful and of interest talking about diving was initiated on 11/30/23. On 04/18/24 at 10:15 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) who cared for the resident prior to being discharged . The CNA revealed that the resident was very aggressive with staff and others. The CNA stated, you must know how to approach the resident. On 04/18/24 at 10:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the unit who confirmed that Resident #234 had increased agitation and did exhibit behaviors of aggression towards staff and other residents. The LPN and the surveyor together reviewed the resident's care plan. The LPN confirmed there was no behavioral care plan developed to address the resident's behavior. The LPN stated the nurses document his/her behavior and interventions in the nurses notes. On 04/18/24 at 11:02 AM, the surveyor interviewed the Director of Nursing (DON) who initiated the care plan on 11/30/23. The DON revealed that she could not recall if the resident had behaviors of being aggressive toward other residents or staff prior to 11/29/23. The DON stated that a care plan for the behavior should have been in place if the resident exhibited the behavior prior to 11/29/23 the date of the incident. The surveyor asked the DON what specific interventions were implemented to prevent the resident from being aggressive toward other residents. The DON stated, I could not recall, I will have to review the record. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/19/24 at 12:30 PM, the surveyor discussed the findings with the facility administration. On 04/22/24 at 10:35 AM, the DON stated the interventions added after the 09/30/23 incident were medication reviews, room changed, and referral to crisis center. The DON further stated that upon the resident's return to the facility, the resident was placed on 1:1 observation. The surveyor reviewed the 1:1 observation logs with the DON as there was no documentation on the log to reflect the behavior exhibited. The DON stated in the presence of the survey team that the 1:1 observation log was to verify that the resident was on 1:1 observation and was not a visual observation. The DON stated Resient #234's behavior was documented in the Progress Notes. There was no care plan implemented with specific interventions to address Resident #234's documented behaviors. The care plan created by the Director of Nursing on 11/30/23, failed to provide the interventions for staff to utilize for addressing the specific documented behaviors. A review of a facility provided untitled instructions on 1:1 observation last revised 07/12/23, indicated the following: Policy: A structured process will be established to identify high risk behaviors and implemented 1:1 interventions when necessary to ensure the safety of residents and staff. The decision to implement 1:1 observation will be based on the resident's assessed risk level. Any resident presenting a direct and aggressive threat to themselves or others will be placed on 1: 1 observation. This intervention requires continuous visual supervision within arm's length of the resident. Staff will document on the designated observation form that the 1:1 occurred. NJAC 8:39-11.2(e).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, review of medical records, and other pertinent facility documentation it was determined that the facility failed to obtain physician orders consistent with professional standards of clinical practice for an orthotic device (used to treat various conditions of the foot and ankle) and for the treatment of a skin tear. This deficient practice was identified for 1 of 28 residents reviewed (Residents #24) and was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist: Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist. According to the Admission Record, Resident #24 was admitted to the facility with the diagnoses which included but was not limited to hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left dominant side, hydrocephalus (fluid build-up in fluid-containing cavities of the brain) and dementia. The quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care dated 03/31/24, indicated that Resident #24 had severe cognitive deficits, had limited range of motion on one side of the body, required maximum assistance with activities of daily living (ADLs) and was dependent on staff for transfers. On 04/17/24 at 9:39 AM, the surveyor interviewed Resident #24 who stated that he/she recently fell in the shower when a male Certified Nursing Assistant (CNA) was transferring him/her. The resident could not provide the surveyor with specifics related to the event of the fall. On 04/17/24 at 9:43 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that he had been employed in the facility for approximately three years. He described the resident as having confusion and was incontinent of bladder and bowel. The CNA stated that the resident required assistance of two staff members for transfers. He stated that the resident required total care with all aspects of activities of daily living (ADLs). CNA #1 indicated that the resident was at risk for falls and required the use of a chair alarm and utilized walker for support and the assistance of two staff member for transfers. The CNA revealed that the resident fell a couple weeks ago but had been receiving therapy. The CNA then added that it took two staff members to assist Resident #24 with showers due to the resident's height and because the resident was a fall risk. CNA #1 stated that he applied an orthotic device to the resident's left leg as it was documented on the CNA assignment schedule. He stated that a timeframe was not documented on the assignment as to when the brace was to be applied or removed, just that the resident was supposed to wear it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 09:53 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who stated that Resident #24 was on skilled physician therapy (PT), occupational therapy (OT) and speech therapy (ST). She stated that PT was working on standing tolerance and transfers. She stated that Resident #24 required two-person assistance with transfers and had weakness on the left side. She stated that the resident had a history of a cranial shunt due to intracranial pressure (ICP). She continued to explain that the resident received OT therapy for range of motion (ROM), strengthen exercises for the left arm. She stated that the resident wore left ankle foot orthosis (AFO): used to stabilize the ankle. She explained that it was a good idea to wear the AFO when standing to prevent accidents. On 04/17/24 at 10:05 AM, the surveyor interviewed the primary care Licensed Practical Nurse (LPN) who stated that she had been employed in the facility for 1 (one) year. The LPN explained that Resident #24 had confusion and required total care with all aspect of ADL's and required a two-person assistance with transfer. She stated that it was important that two staff members assisted the resident during transfers to help protect the resident and the staff from getting injured. The LPN went into the resident's room to see what the resident was wearing on the left lower extremity and then confirmed that the resident was wearing a AFO on the left lower extremity. The LPN stated that Resident #24 fell two weeks ago but that she could not recall the details. She stated that the resident had a left elbow skin tear, but it had healed. She stated that she was not sure how developed. The surveyor reviewed the Treatment Administration Record (TAR) for April 2023 and there was no physician's order for an AFO to the left foot. There was also no documentation on who was to apply the brace, when the brace was to be applied or removed. The surveyor reviewed the TAR for March 2024, and there was no documentation for a physician's order that the staff performed treatments to skin tear of the back of the left arm that was sustained when the resident fell on [DATE]. The surveyor reviewed the facility incident and accident report and investigation dated 03/13/24 at 3:30 PM, which indicated that after Resident #24 had a shower, the resident was transferred to the wheelchair, lost his/her balance and was lowered to the ground. In the process the resident sustained a skin tear to the left elbow which was treated with bacitracin (antibiotic ointment) and a band aid. The report also indicated that the residents Responsible Party (RP) was notified and the Physician was notified. There was no documentation that indicated a treatment order was obtained from the physician. The surveyor reviewed Resident #24's Care Plan (CP), which indicated that the resident had a brace to the left lower leg. The CP also indicated that the resident's skin should be checked under the brace every shift. The CP also indicated that the resident fell on [DATE]. The CP reflected that while transferring the resident to the shower chair the resident lost his/her balance and was lowered to the floor and developed a skin tear. The Progress note dated 3/13/2024 at 10:39 PM (22:39) indicated the following: Health Status Note Text: Post fall- notified by CNA that resident begin to lose balance and was lowered to the ground by the CAN while being transferred into chair after shower. On assessment resident noted to have skin tear to back of left arm which was treated with bacitracin and a band aid. Resident alert and stable no complaints of pain. Will continue to monitor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7:00 AM-7:00 PM, CNA Assignment Sheet dated 03/13/24, indicated that the resident required a 2-person assistance with transfers and worn a brace to the left lower extremity. On 04/17/24 at 10:23 AM, the surveyor interviewed the Licensed practical Nurse Unit Manager (LPN/UM) on the B Unit second floor who had been employed in the facility for [AGE] years. The LPN/UM stated that Resident #24 was alert and oriented to person and required extensive assist with ADLs. She stated that the resident required 2-person transfer for over 5 months. She explained that Resident #24 had poor balance and was also very tall, so for his safety and staff safety, he/she required two-person assistance with all transfers. She stated that the resident fell in the shower room a month ago. The LPN/UM revealed that the CNA assigned to Resident #24 on 03/13/24 on the 3:00 PM-11:00 PM shift did not follow the resident's plan of care and transferred the resident by himself. She stated that the resident sustained a skin tear to the left elbow during the fall. She continued to explain that the resident had an AFO brace on the left leg. She stated that the brace was applied by the CNA during morning care. She explained that the AFO brace was importance to wear to stabilize the resident's left leg. The LPN/UM stated there should be a physician's order for orthotic device. She stated that the order should contain information on when the AFO should be applied, removed and who was to apply it. The LPN/UM reviewed the physician's orders in the presence of the surveyor and confirmed that there were no physicians order for the AFO. She also stated that the orthotic device was documented on the resident's care plan. She stated that physicians order for the AFO wound have been important to have so the staff knew when to apply and when to remove the AFO. She stated that the AFO should have been documented on the TAR (Treatment Administration Record) and the TAR should have contained an order for application, removal and to check skin every shift. She stated that the nurse should sign out on the TAR that the AFO was being applied, removed and that the nurses were checking the resident's skin under the AFO. The LPN/UM then stated that stated she would correct the error immediately and would obtain and physician's order for the AFO and would implement the order on the TAR. On 04/17/24 at 10:51 AM, the surveyor interviewed the CNA who stated that he worked for the agency and worked 2-3 days a week at the facility. He stated that he was familiar with the residents in the facility. He stated that he worked on 03/13/24 on the 3:00 PM-11:00 PM shift and provided care to Resident #24. He stated that while he was providing a shower to Resident #24, he transferred the resident in the shower independently and the resident lost his/her balance and was lowered to the floor. He stated that the resident sustained a skin tear on left elbow area. He admitted that he did not review the assignment sheet and did not know that the resident was a two-person transfer. He stated that he should have received a briefing from the other nurses prior to showering the resident and received help with transferring of the resident. The surveyor asked the CNA if there were facility documents that he could have referred to regarding how to care for the residents and he indicated that there was a section on the CNA assignment that indicated how many people were supposed to assist a resident with transfers. He stated that the facility Administration educated the CNA, and they also performed a shadowing with another CNA to observe him while he transferred a resident so that I didn't make that mistake again. The CNA then added that the resident had bare feet during the transfer and was not wearing a AFO at the time of the fall. On 04/17/24 at 12:44 PM, the surveyor interviewed the LPN/UM. The LPN/UM reviewed the March TAR in the presence of the surveyor and confirmed that there was no treatment order documented on the TAR for the skin tear that was sustained during the fall on 03/13/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 1:17 PM, the surveyor interviewed the DOR who stated resident had a AFO (ankle foot orthosis). The DOR stated that Resident #24 was to wear when standing and with transfers. She stated that the resident did not need to wear it at night in bed. On 04/17/24 at 1:27 PM, the surveyor interviewed the DOR who stated that the Resident #24 has had the AFO since had been here for about 2 years. She stated that the AFO should have had a physician's order. She stated that when therapy recommended a splint or brace, they would let the nurse know and the nurses will put the physicians order in the electronic medical record. On 04/18/24 at 10:03 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed that a physician's order was required for the treatment of a skin tear or the use of an orthotic device. The undated policy titled, Equipment-Use for all Residents indicated that splints are individualized per patient and that request or the need for special equipment should be referred to the rehabilitation Department. The undated policy titled, Charting and Documentation indicated that all observations, medications administered, services performed, etc. must be documented in the clinical record. Documentation of treatments and procedures shall include care-specific details and shall include at minimum: -The date and time the procedure and treatment were provided. -The name and the title of the individual who provided the care. -The assessment data and/or any unusual findings obtained during the treatment/procedure. -How the resident tolerated the procedure/treatment. -Whether the resident refused the treatment/procedure. -Notification of the family, physician and or other staff if indicated. -The signature and title of the individual documenting. The undated facility policy titled, Accident and Incidents indicated that the injured persons physician was to be notified and his or her instructions. NJAC 8:39-27.1 (a) (d) (1-3)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Complaint NJ #165621 Based on record review, interview, and review of pertinent documentation, it was determined that the facility failed to a.) adequately supervise a cognitively impaired resident (Resident # 535) with exit seeking behavior from eloping the facility. This posed the likelihood of serious injury, serious harm, serious impairment or death for 1 of 3 residents reviewed for wandering/elopement. A review of a closed record revealed a Progress Note (PN) dated 05/28/23, identified that staff were unable to locate Resident #535 in the facility for approximately one hour. Resident # 535 was found at a local restaurant located near the facility. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 05/28/23 and was identified on 04/17/24. The IJ template was given to the Licensed Nursing Home Administrator (LNHA) on 04/17/24 at 3:10 PM. An acceptable removal plan was received on 04/18/24 at 1:52 PM and was verified on-site on 04/18/24 at 2:00 PM. The removal plan indicated the facility took the following steps to prevent serious harm from occurring or recurring: 1. Resident 535 was discharged from the facility; 2. All 9 residents at risk for wandering or elopement had a wandering risk assessment completed and updated Care plans. Assessments reviewed by the Nursing administration, Administrator, Assistant Administrator, Nurse Practitioner (NP), Activities, and Social Work team. The nine (9) residents indicated were reviewed; and 3. Staff education via facility wide text message portal which consisted of where to find all residents at risk for elopement within the electronic medical record, the requirement to review the at-risk residents, and interventions at each shift. Department heads with departments that don't have access to the electronic medical record, educated their staff that the electronic medical record list will be printed and posted at the time clock and the pictures of the residents at risk will be kept at the reception desk. The lists will be updated with any changes through the weekly intervention meeting or as needed. F 689 remains a deficiency at a scope and severity of a D based on the following: The facility further failed to b.) maintain the safety of a resident who was identified as a fall risk by not following the plan of care for 1 of 32 residents (Resident #24) reviewed for falls. The evidence was as follows: Part A (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy for Wandering, Unsafe Resident, undated, included but was not limited to: The facility will strive to prevent unsafe wandering . for residents who are at risk for elopement. 1. The staff will identify residents who are at risk . because of unsafe wandering (including elopement). 2. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement . Interventions to try to maintain safety, such as a detailed monitoring plan will be included. 5. When the resident returns the Director of Nursing or charge nurse shall: f. document relevant information in the resident's medical record. On 04/17/24, the surveyor reviewed Resident #535's electronic medical record. A review of the Admission Record dated 04/13/22, documented that Resident #535 had diagnoses which included but were not limited to: senile degeneration of the brain, dementia with behavioral disturbance, and delirium. A review of a Psychological Evaluation dated 04/19/22, included but was not limited to; resident was being referred for acting more confused . staff says he/she is wandering. A review of the current Comprehensive Care Plan on 04/20/22, revealed that the resident was an elopement risk related to dementia with goals to not leave the building unescorted, to ensure supervision while outside, and if unable to redirect resident from exit seeking, stay with resident. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 03/16/23, reflected the resident had a Brief Interview for Mental Status (BIMS) of 08 out of 15, indicating moderate cognitive impairment. Review of the PN dated 04/20/23, indicated that the resident tried to elope, redirected and wander guard was applied to the left ankle. Review of the PN dated 05/02/23, revealed that the resident removed his/her wander guard, and it was not reapplied. There were no new interventions added to the care plan to prevent further exit seeking. Review of the PN dated 05/03/23, reflected that the resident was found on the elevator. The resident stated, I want to go home . I'm like in a jail here. There were no new interventions added to the care plan to prevent further exit seeking. Review of the Interdisciplinary Team notes dated 05/04/23, revealed that the resident continued to remove the wander guard and the wander guard was discontinued. The document further revealed, Observation in place and resident not a wanderer as [he/she] has a plan to where he/she is going. There were no new interventions added to the care plan to prevent further exit seeking or that the resident's wander guard had been discontinued. The Wandering Risk Scale [an assessment tool] revealed a 9, which indicated at risk to wander. Review of the PN dated 05/22/23, revealed that the resident stated he/she was leaving, had a packed bag and was headed toward the elevator and was redirected. There were no further interventions added to the care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's Reportable Event Record/Report dated 05/28/23, identified that Resident #535 exited/eloped the facility undetected through the front door late morning. The resident was found by staff almost an hour later at a restaurant near the facility. On 05/28/23, Resident # 535 was transferred to another facility that had a locked unit. Review of the May 2023 Treatment Administration Record, included an order for OBSERVATION CHECKS every hour for OBSERVATION CHECKS-Start Date 05/18/2023 1200 [12:00 PM]. The correlating PN dated 05/19/23, documented resident is on observation monitoring r/t [related to] going in and out of other resident's rooms. On 04/17/24 at 10:46 AM, the surveyor interviewed the receptionist who stated she worked at the facility since 04/20/22, but she was not working on 5/28/2023. The receptionist stated residents who were an elopement risk or wander would wear a wander guard. She stated the wander guard and alarm would go off if a resident were close to the monitoring device. If a resident did not wear a wander guard, she could use a button to lock the front door. She stated there was a list and pictures at the front desk of residents who wander. On 04/17/2024, the Director of Nursing (DON) provided a statement dated 6/1/2023, from the receptionist who was working on 05/28/23, when the resident eloped which indicated, I was at the front desk the entire time and did not see resident leave. The receptionist who was working on 05/28/23, is no longer employed at the facility and could not be interviewed. On 04/17/24 at 10:54 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who worked on the unit the day Resident #535 eloped. She stated, I think I remember the primary care nurse told me that the resident was missing and that she thought the resident was found at a restaurant in the area. The LPN stated the normal process for a missing resident would be to search the unit, the building, announce the code, and all start searching. On 04/17/24 at 11:31 AM, the surveyor interviewed the Director of Nursing (DON) who stated she has been at the facility since 02/14/23. The DON stated the process for a resident who was an elopement risk would be to do an assessment, apply a wander guard depending on the assessment, and ensure there was a photo at the reception desk. When asked if the resident were to remove the wander guard, the DON stated it would be placed somewhere like the wheelchair or the walker if the resident used one. The DON further stated that interventions for an elopement risk or wanderer would include a wander guard, name, and photo at the reception desk, and to inform the staff. The DON explained the day Resident #535 eloped was a weekend and the staff called her. She instructed the staff to do a building sweep, open all doors, check all exits, check the stair wells, basement, inside and out. She stated the police, physician, Licensed Nursing Home Administrator (LNHA) and family were notified. She was unsure how long the resident was missing, where he/she was found, or how he/she was returned to the facility. On 04/17/24 at 1:02 PM, the surveyor interviewed the then LNHA, current Assistant LNHA, who stated she did not remember when she was made aware that Resident #535 was identified as an elopement risk. She stated the resident eloped, was found, and brought back to the facility by a staff member. The resident was transferred to a facility with a locked unit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Manchester	1770 Tobias Avenue Manchester, NJ 08759

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/17/24 at 1:11 PM, the then LNHA stated the front desk has a board and folder with pictures of wanderers/elopement risk residents and that the camera was working but the views did not show what we needed to see. She stated the resident had a wandering assessment on admission 04/13/22 and on 05/04/23, both with a score of 09 which indicated at risk for wandering. She stated she was not aware of any elopement seeking behaviors but would have to check. She stated the resident was never a wander risk inside the facility. The surveyor reviewed the 05/03/23 PN and asked if the documentation constituted an elopement behavior. The LNHA stated, I don't know if that constitutes an elopement behavior. On 04/22/24 at 10:39 AM, the surveyor in the presence of the survey team, interviewed the then LNHA who stated, I do not remember at that time if Resident #535 was an elopement risk. She stated there was conflicting documentation in the medical record and that when the resident would walk around, he/she had a goal so [he/she] was not a wanderer because [he/she] knew where [he/she] wanted to go. 33106 Part B According to the Admission Record, Resident #24 was admitted to the facility with the diagnoses which included but was not limited to hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the left dominant side, hydrocephalus (fluid build-up in fluid-containing cavities of the brain) and dementia. The quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care dated 03/31/24, indicated that Resident #24 had severe cognitive deficits, had limited range of motion on one side of the body, required maximum assistance with activities of daily living (ADLs) and was dependent on staff for transfers. On 04/17/24 at 09:39 AM, the surveyor interviewed Resident #24 who stated that he/she recently fell in the shower when a male Certified Nursing Assistant (CNA) was transferring him/her. The resident could not provide the surveyor with specifics due to cognitive deficits. The resident did not appear to have any injury on the upper arms. On 04/17/24 at 09:43 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #1) who stated that he had been employed in the facility for approximately 3 (three) years. He described the resident as having confusion and was incontinent of bladder and bowel. CNA #1 stated that the resident required assistance of two staff members for transfers. He stated that the resident required total care with all aspects of activities of daily living (ADLs). He continued to explain that the resident was at risk for falls and required the use of a chair alarm and utilized walker for support with assistance of two staff member for transfers. CNA #1 revealed that the resident fell a couple weeks ago. He stated that the resident currently received therapy. CNA #1 then added that it took two staff members to assist Resident #24 with showers due to the resident's height and because the resident was a fall risk. CNA #1 stated that he applied an orthotic device to the resident's left leg and that it was indicated on CNA #1's assignment schedule. He revealed that a timeframe was not documented on the assignment as to when the brace was to be applied or removed, just that the resident was supposed to wear it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/17/24 at 09:53 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who stated that Resident #24 was on skilled physician therapy (PT), occupational therapy (OT) and speech therapy (ST). She stated that PT was working on standing tolerance and transfers. She stated that the resident required two-person assistance with transfers and had weakness on the left side. She stated that the resident had a history of a cranial shunt due to intracranial pressure (ICP). She continued to explain that the resident received OT therapy for range of motion (ROM), strengthen exercises for the left arm. She stated that the resident wore left Ankle foot orthosis (AFO): used to stabilize the ankle. She explained that it was a good idea to wear the AFO when standing to prevent accidents. On 04/17/24 at 10:05 AM, the surveyor interviewed the primary care Licensed Practical Nurse (LPN) who stated that she had been employed in the facility for 1 (one) year. The LPN explained that Resident #24 had confusion and required total care with all aspect of ADL's and required a two-person assistance with transfer. She stated that it was important that two staff members assisted the resident during transfers to help protect the resident and the staff from getting injured. The surveyor reviewed Resident #24's Care Plan (CP), which indicated that the resident had a brace to the left lower leg. The CP intervention dated 02/24/21, indicated that the resident required extensive assistance of two staff members for transfers. The CP also indicated that the resident fell on [DATE] while CNA was transferring the resident to the shower chair, the resident lost his/her balance and was lowered to the floor and developed a skin tear. The Progress note dated 3/13/2024 at 10:39 PM (22:39), indicated the following: Health Status Note Text: Post fall- notified by CNA that resident begin to lose balance and was lowered to the ground by the CNA while being transferred into chair after shower. On assessment resident noted to have skin tear to back of left arm which was treated with Bacitracin and a band aid. Resident alert and stable no complaints of pain. Will continue to monitor. The 7:00 AM-7:00 PM, CNA Assignment Sheet dated 03/13/24, indicated that the resident required a 2-person assistance with transfers and wore a brace to the left lower leg. On 04/17/24 at 10:23 AM, the surveyor interviewed the Licensed practical Nurse Unit Manager (LPN/UM) on the B Unit second floor for a couple year and employed in the facility for [AGE] years. The LPN/UM stated that Resident #24 was alert and oriented to person and required extensive assist with ADLs. She stated that the resident required 2-person transfer for over 5 months. She explained that Resident #24 had poor balance and was also very tall, so for his safety and staff safety, he/she required two-person assistance with all transfers. She stated that the resident fell in the shower room a month ago. She revealed that the CNA assigned to Resident #24 on 03/13/24 on the 3:00 PM-11:00 PM shift did not follow the resident's plan of care and transferred the resident by himself. She stated that the resident sustained a skin tear to the left elbow during the fall. She continued to explain that the resident had an AFO brace on the left leg. She stated that the brace was applied by the CNA during morning care. She explained that the AFO brace was importance to wear to stabilize the resident's left leg. She also stated that the orthotic device was documented on the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/17/24 at 10:51 AM, the surveyor interviewed the CNA #2 who stated that he worked for the agency and worked 2-3 days a week at the facility. He stated that he was familiar with the residents in the facility. He stated that he worked on 03/13/24 on the 3:00 PM-11:00 PM shift and provided care to Resident #24. He stated that while he was providing a shower to Resident #24, he transferred the resident in the shower independently and resident lost his/her balance and was lowered to the floor. He stated that the resident sustained a skin tear on left elbow area. He admitted that he did not review the assignment sheet and did not know that the resident was a two-person transfer. He stated that he should have received a briefing from the other nurses prior to showering and received help with transferring of the resident. The surveyor asked CNA #2 if there were facility documents that he could have referred to regarding how to care for the residents and he indicated that there was a section on the CNA assignment that indicated how many people were supposed to assist a resident with transfers. He stated that the facility Administration educated CNA #2, and they also performed a shadowing with another CNA to observe him while he transferred a resident so that I didn't make that mistake again. CNA #2 added that the resident had bare feet during the transfer and was not wearing a AFO at the time of the fall. On 04/17/24 at 01:17 PM, the surveyor interviewed the DOR who stated resident had a AFO (ankle foot orthosis). The DOR stated that Resident #24 Res was to wear when standing and with transfers. She stated that the resident did not need to wear it at night in bed. The DOR provided the surveyor with a Physical Therapy Treatment Encounter dated 03/25/24, which indicated that Resident #24 required maximum assistance with two staff members with AFO on the left foot. The undated facility policy titled, Care Plans indicated that the comprehensive care plan was developed for each resident that identified the highest level of functioning the resident may be expected to attain and identify the professional services that are responsible for each element of care. NJAC 8:39-27.1 (a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to complete and maintain an ongoing communication record between the facility and the dialysis center for 1 of 2 residents (Resident #19) reviewed for dialysis. The deficient practice was evidenced by the following: A review of the facility policy Hemodialysis Communication undated, included but was not limited to: to have effective communication . between facility and dialysis center . Steps . ensure the resident has their communication binder with them and filled out completely to include pre and post dialysis weights, vitals, and any medications provided . According to the Admission Record, Resident #19 was admitted with diagnoses which included but were not limited to acute kidney failure, psychosis, Dementia, and dependence on renal dialysis. The resident-centered comprehensive Care Plan (CP) included a focus area . attend dialysis Tuesday, Thursdays, and Saturdays. Interventions included to ensure the resident has the dialysis communication book when going to treatments. The Quarterly Minimum Data Set (MDS) a tool used to facilitate care dated 01/17/24, documented a Brief Interview for Mental Status (BIMS) as resident is rarely/never understood and was not conducted. On 04/12/24 at 7:05 AM, the surveyor observed Resident #19 sleeping in bed. At that time, the surveyor reviewed the resident's dialysis communication binder which started January 2024 and documented the following: January 2024: Included ten forms. Nine of ten were missing the resident's name; four of ten had incomplete pre-dialysis information from the facility; and two of ten had incomplete post-dialysis information required from the dialysis facility. Two of the twelve dialysis treatment forms were missing. February 2024: Included 10 forms. Nine of ten were missing the resident's name; two of ten had incomplete pre-dialysis information; and one of ten had incomplete post-dialysis information. Two of the twelve dialysis treatment forms were missing. March 2024: Included four forms. Four of four were missing the resident's name; Two of four had incomplete pre-dialysis information; and eight of twelve dialysis treatment forms were missing. April 2024, through 04/12/24: Included five forms. Five of five were missing the resident's name. On 04/16/24 at 9:22 AM, the surveyor interviewed the direct care Licensed Practical Nurse (LPN) who stated Resident #19 would be sent with the dialysis communication book to treatment. She stated that it was the nurse's responsibility to document the vitals and that the dialysis nurse would document the vitals when the resident was finished with the treatment. She further stated that the vitals should be completely filled out so we can communicate with dialysis and provide the proper care needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/24 at 8:38 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the facility filled out the pre-dialysis information and the dialysis center filled out the post-dialysis information. The DON stated that if that was not completely filled out, that it indicated that the post-dialysis information was incomplete, and the nurse must call the dialysis center to obtain all of the missing information. She stated the facility pre-dialysis portion should be completed and that there should be a communication sheet for every dialysis visit. The surveyor asked to review the communication book for Resident #19 with the DON. The DON confirmed that there was no name on the pages and that it was important to have the resident name on all the pages in case a page was separated from the binder. The DON acknowledged there were many blank pages and stated it was the Unit Managers (UM) responsibility to check the dialysis communication sheets to ensure completeness. On 04/17/24 at 8:45 AM, the surveyor interviewed the LPN UM who stated she was responsible to check the dialysis communication sheets to ensure they were complete and if there were orders or recommendations from the dialysis center. At that time, the surveyor reviewed the facility policy with the DON and the LPN UM. Both confirmed the facility policy was not being followed. On 04/19/24 at 11:49 AM, the surveyor informed the facility Administration of the concern and was afforded the opportunity to provide additional information. On 04/22/24, the facility Administration had no additional information to provide. NJAC 8:39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37791 Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 3 of 3 forms provided: This deficient practice was evidenced by the following: On 4/17/24 at 10:45 AM, the surveyor reviewed the facility provided DEA 222 forms which revealed on three of the three provided forms Part 5, had not been completed upon receipt of the medications from the Provider Pharmacy as instructed on the reverse of the ordering form. The forms were as follows: Order form number: 231659497; 231659498; 23165949. On 4/17/24 at 10:50 AM, the surveyor and DON reviewed the provided DEA 222 forms. The DON acknowledged she should have completed in Part 5 as instructed on the reverse of the DEA 222 form as required. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item . NJAC 8:39- 29.2(d), 29.7(c)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure that staff provided a resident with the appropriate physician ordered liquid consistency. This posed the likelihood of serious harm to the health and well-being of Resident #24. This resulted in an Immediate Jeopardy (IJ). This deficient practice occurred for 1 of 9 resident (Resident #24) reviewed for physician ordered pudding thick liquid consistency and was evidenced by the following: On 04/12/24 at 8:40 AM, the surveyor observed a Certified Nurse Aide (CNA) adding two thickener packets to Resident #24's coffee, instead of the required four, and then provided the coffee to the resident. Resident #24 was then observed drinking the coffee from the nine-ounce cup that was filled closely to the top, and Resident #24 then coughed. The meal ticket on Resident #24's tray at that time identified Resident #24's diet as Puree, Pudding Thick at the top and !!!Pudding Thick!!! at the bottom. The IJ was identified and began on 04/12/24. The IJ template was provided to the Licensed Nursing Home Administrator (LNHA) at 04/12/24 at 12:51 PM. An acceptable removal plan was received on 04/12/24 at 3:35 PM, and was verified on-site on 04/17/24 at 12:09 PM. An acceptable removal plan was received on 04/12/24 at 3:37 PM, indicating the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1. Resident #24 was immediately examined by the Nurse Practitioner. 2. The physician was called and made aware. 3. The Nurse Aide was immediately in-serviced which included return demonstration. All other staff who may serve Resident # 24 as well as any other staff who may serve other residents with thickened liquids have been in-serviced with return demonstration. The evidence was as follows: On 04/12/24 at 8:31 AM, during a surveyor interview with Resident #24 a Certified Nurse Aide (CNA) brought the resident's meal tray into the room and placed it on the bed-side table. The CNA informed the resident he was going to get the resident coffee and then exited the room. The CNA returned with a 9-ounce burgundy coffee cup that was filled close to the top of the mug with coffee. (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/12/24 at 8:40 AM, the CNA removed two packages of thickener from a drawer next to the resident's bed, then emptied the contents of both thickener packets into the coffee, stirred the contents and placed the cup in front of the resident. The CNA told the resident, go ahead and eat. The resident then proceeded to pick up the coffee cup, put his/her head back and proceeded to drink the coffee from the mug. Resident #24 again was observed coughing. The CNA then opened a coffee creamer, picked up the coffee and stirred in the creamer and again placed the coffee cup next to the resident. At that time, the surveyor observed a meal ticket on Resident #24's tray and asked the CNA to show the surveyor the ticket. The ticket identified Resident #24's diet as Puree, Pudding Thick at the top and !!!Pudding Thick!!! at the bottom. The surveyor asked the CNA what type of liquids the resident was supposed to consume, and the CNA stated, it is supposed to be nectar. The surveyor asked the CNA if he looked at the ticket and the CNA stated, I looked at the ticket. On 04/12/24 at 8:45 AM, the surveyor exited the room to inform the Licensed Practical Nurse, Charge Nurse (LPN/CN) of the surveyor's observations and asked what type of liquids the resident was prescribed. The LPN/CN stated the resident was on pudding thick liquids and accompanied the surveyor to Resident #24's room. The LPN/CN looked at the coffee and proceeded to take a spoon and lift up the coffee and drop it back into the cup. The coffee was observed to freely flow back into the cup and was not pudding thick in appearance. The surveyor asked if the coffee was the appropriate consistency. The LPN/CN stated the coffee was not pudding thick consistency and was not appropriate for the resident. At that time, in Resident #24's room, affixed to the wall close to the bed, was an 8 1/2 X 11-inch sheet of paper with large black printed instructions which indicated: Pudding thick liquids -2 packets per 5 ounces. Diet: Pureed. A review of the Thickened Liquids, Fluid Restrictions and NPO [nothing by mouth] Policy dated 05/2023, included but was not limited to: Staff Responsibilities . 5. Nurse's aides are able to use prepared thickened liquid preparation from the dietary department . 6. Staff who were educated on the process are able to use thickening packet to prepare appropriate fluids. On 04/12/24 at 9:00 AM, the surveyor reviewed Resident #24's electronic medical record. Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated 12/30/23, reflected the resident had a brief interview for mental status (BIMS) score of 05 out of 15, indicating that the resident had a severely impaired cognition. Section K revealed the resident received a Mechanically Altered and Therapeutic Diet. Section GG was coded as 04 which indicated that the resident required supervision for eating. Review of the Admission Record dated 04/12/24, revealed that Resident #24 had diagnoses which included dysphagia (difficulty swallowing), oropharyngeal phase (middle part of throat), cerebral infarction, and hemiplegia and hemiparesis. Review of a Physician Order dated 02/16/24, revealed a Diet order for a Consistent Carbohydrate Diet, Puree Texture, Pudding consistency, No Straws, 2 packs of honey thickener to 5 ounces. (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Resident's current Comprehensive Care Plan documented a Focus area for the resident having a chewing and swallowing deficit which was initiated on 02/16/24. The Goal revealed the resident will chew and swallow the least restrictive diet without overt [signs and symptoms] of aspiration 95%-100% of the time given [minimum cues] which was initiated 02/16/24 with a target date of 06/29/24. The Intervention was to receive skilled [Speech Therapy] 12 sessions/30 days for [treatment] of oropharyngeal dysphagia, cognitive-linguistic deficits, [patient] caregiver training and [discharge] planning which was initiated 02/16/24. Review of the Key Information section of the electronic medical record revealed Precautions, Aspiration Precautions Puree/Pudding Thick. Review of a Speech Therapy Treatment Encounter Note signed by the Speech Therapist on 04/11/24 at 3:36 PM revealed Precautions: Aspirations precautions, Puree/pudding thick. The International Dysphagia Diet Standardization Initiative 2016: Oral Intake: Current Drinks/Liquids=Extremely Thick Drinks; Current Foods/Solids=Puree Foods; Functional Status as a Result of Skilled Interventions: Oral Intake: Current Liquids = Pudding thick liquids, Current Solids= Puree Consistencies. Review of a Nurse Practitioner Note dated 08/28/23, timed at 10:40 AM, revealed that the resident was post hospitalization for TIA [Transient Ischemic Attack], LL PNA [Lower Lobe Pneumonia] from 8/8 to 8/13. The Plan included the following: Problem/Diagnosis Status Notes/Considerations Action Orders/Recommendations; At risk for poor prognosis, expect decline in cognitive/physical function, risk of pneumonia, swallowing difficulties, weight loss and falls; Diagnoses: Oropharyngeal dysphagia Stable Chronic Per medical records .Monitor for s/s of aspiration and if suspected stat [immediate] CXR [chest X-Ray], add steroids, duonebs [respiratory treatment], oxygen and antibiotics as warranted. Pneumonia, unspecified organism Stable Chronic Per hospitalization ,d+[DATE] to 8/13. Completed Augmentin monitor for recurrent symptoms. Monitor, Evaluate, Assess, Treat Monitor SPO2 and give supplemental O2 as needed to maintain SPO2 [blood oxygen level] > 92%. High risk for aspiration if suspected obtain stat imaging, steroids, duonebs and antibiotics as warranted. Review of a Registered Dietitian Quarterly Note, dated 03/26/24, revealed Puree diet with pudding thick liquids. (continued on next page)

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	315196	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aristacare at Manchester	1770 Tobias Avenue Manchester, NJ 08759

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/12/24 at 9:50 AM, the surveyor interviewed the Speech Therapist (ST) who stated she worked at the facility for two and half years and was responsible for prescribing resident diet consistencies, working with residents on swallowing exercises and education for staff and residents. The surveyor asked the ST if she had been made aware of the observed concerns with Resident #24's liquid consistency. The ST stated she had been informed by the nurse that the liquids were not properly thickened and did not observe the resident after the incident. The ST confirmed that Resident #24's diet order was for puree food and pudding thick liquids and staff was to use 2 thickener packs for 5 ounces of liquids, and 4 packets for 8 ounces of liquid. The surveyor asked what would happen if Resident #24 did not receive the proper liquid consistency. The ST stated there was a potential for aspiration as the physician ordered aspiration precautions. On 04/12/24 at 8:53 AM, the surveyor interviewed the Registered Dietitian (RD) regarding Resident #24's physician ordered diet. The RD stated the resident had recently declined and the diet consistency had been downgraded. The surveyor asked the RD if it was important for Resident #24 to be on a thickened liquid diet and the RD stated, if the resident had pudding thick liquid on the tray ticket, absolutely, they should receive it. The surveyor asked if pudding thick liquids could be drunk from a cup and the RD stated, no, it should be by a spoon. On 04/12/24 at 9:17 AM, the surveyor interviewed the Food Service Director (FSD) regarding who was responsible for thickening liquids. The FSD stated the nursing department was responsible to thicken liquids. One packet of thickener would be used for 4 ounces of liquid to thicken to nectar thick, spoon like would require 2 packets for 4 ounces and pudding thick would require 3 packets for 4 ounces. The surveyor reviewed the thickener packet provided by the FSD which revealed: Add 1 packet to four ounces of liquid, stir with a spoon or fork for approximately 15 seconds or until thickener is dissolved. Allow 1 to 4 minutes for product to reach desired thickness. Products may thicken slightly over time. The amount of thickener may be adjusted to meet your individual needs. Results may vary depending on source of water, type, and temperature of beverages of foods. For spoon-like consistency: Add two packets to 4 ounces of liquid. On 04/12/24 at 10:28 AM, the surveyor, in the presence of four other surveyors, interviewed the Director of Nursing (DON). The surveyor asked the DON to explain the process that was in place for staff to provide thickened liquids to a resident. The DON stated the resident's meal tray would be delivered from the kitchen; a nurse would read the ticket to determine if the resident had a modified diet; if the resident had a thickened liquid diet nursing was responsible to thicken the liquids as there were no pre-thickened liquids for the past few months and the packets of thickener were available on the resident units. We thicken it to the appropriate texture and then take it to the resident, and we pour the coffee as it doesn't come up on the tray. The DON further stated, we are supposed to be completing competencies for thickening liquids. The surveyor then asked if all staff had been trained on thickening liquids for the residents and the DON stated, I don't want to say competencies, and then stated, in services. The DON stated, they should be doing thickened liquid competencies and the nurses know the consistency of the diets and liquids and should be monitoring that. The surveyor asked the DON if the nurses should be checking the consistency of the liquids and she stated, I would hope so. The surveyor asked if Resident #24's liquids should have 2 packets of thickener added to 8 ounces to make it pudding consistency, and the DON stated, no. The surveyor asked if that was a concern and the DON stated, yes. (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/19/24 at 11:19 AM, the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA) and Corporate Clinical Officer (CCO) presented additional information to the survey team. The LNHA stated, I agree, they didn't follow the doctor order, and confirmed by the AA. NJAC 8:39-17.4 (a)1-2; 27.1(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43308 Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to accurately document in the medical records. This deficient practice was identified for 1 of 29 residents (Resident #183) medical records reviewed and was evidenced by the following: The surveyor reviewed the medical record for Resident #183. A review of the Admission Record face sheet reflected that the resident was admitted to the facility with diagnoses that included, lack of coordination, type 2 diabetes mellitus (high blood glucose), and abnormalities of gait (pattern a person walks) and mobility. A review of the Incident Report revealed that a staff member (Certified Nursing Assistant - CNA) bumped into the resident with a meal cart resulting in the resident sustaining a skin tear on their right third toe on 2/24/23 at 8:45 AM. A review of the Full QA [Quality Assurance] Report revealed investigative statements from the nurse, the resident, and the witnessed CNA were obtained. It further indicated the CNA immediately informed the nurse, the resident was assessed, a treatment was ordered, and the physician and family was notified. A review of the Progress Notes (PN) from February 2023, revealed there was no progress note in the electronic medical record (EMR) on 2/24/23 during the 7 AM to 3 PM regarding the incident not until 2/25/23 at 02:37 (2:37 AM), which indicated the resident had redness noted to the third right toe and the physician ordered an X-ray with a bacitracin (topical antibiotic ointment) treatment. On 04/17/24 at 09:30 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated that they completed an accident/incident report and wrote a progress note in the electronic medical record (EMR) for any incident that occurred. She stated that it was important to document a progress note in the EMR because it was a communication tool from shift to shift, so everyone was aware of what happened with the resident. On 04/17/24 at 09:35 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated the process for any incident would be to call the nurse and to stay with the resident. The CNA stated that she would then write a statement for the incident report and describe what she saw if it was witnessed. She further stated that if it was unwitnessed and the resident was her resident then she would describe what the resident was doing prior to the incident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/17/24 at 11:03 AM, the surveyor interviewed LPN #2 who stated the process for any incidents was to assess the resident. She then stated that she would call the supervisor to complete a full head to toe assessment. LPN #2 stated that the nurses would get statements from staff regarding the incident, notify the family and the physician. She stated they would then complete an incident report and write a progress note in the EMR. When asked should there be a progress note of the incident. LPN #2 stated that a progress note should be done with the incident report. She explained it was important to also document a progress note in the EMR, so the oncoming shift knew what was happening. She further explained it was our way of communicating and this way all staff that has access to it is aware of what occurred. LPN #2 concluded they documented for three (3) days after any incident in the EMR. On 04/17/24 at 11:04 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that the protocol for any incident at this facility was to get a full assessment of the resident, the nurses would complete the incident report and collect statements, and document a progress note in the EMR. The LPN/UM stated that there should be a progress note in the EMR because the progress note informs the facility and all staff of what occurred with the resident, so they are aware. She further stated that the progress notes are a communication tool for the staff and physicians as well as the resident and the power of attorney (POA) so the communication could be successful. She then stated that the nurses also document on the 24-hour report daily, so all the nurses were aware of what happened in those 24 hours. The LPN/UM stated that if a resident was bumped by a cart and received a skin tear then an incident report would be completed. She further stated that they would obtain statements from the resident if alert, from staff that was around, and from other staff to see what the resident was doing prior to the incident. When asked would there also be a progress note in the EMR? The LPN/UM emphasized absolutely there should be a progress note because it was an incident, and we need to know what happened. She stated that the resident assessment, and physician and family should be notified. On 04/18/24 at 09:31 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the process for any incidents was that staff would notify the supervisor, the physician, and the family. The nurses would assess the resident and an incident report was completed. She stated that the staff then wrote statements which were collected from anyone that witnessed the incident. She clarified if the incident was unwitnessed then the nurse would collect the statements from the staff that seen the resident prior to the incident. The DON stated that the nurses would write a progress note of the incident, or they would just write their note in the incident report. She then stated that if the nurses completed an incident report, then they did not have write a progress note in the EMR. She explained that they did not have a write a progress note, if they wrote in the incident report because the incident report could be printed out. When asked how would staff be aware of the incident? The DON stated that staff were aware of the incident from the 24-hour report. When asked when should a progress note be written? The DON stated it should be written for any change because it was communication tool for the staff to be informed about the resident. She stated that a progress note was considered a part of the medical record. On 04/19/24 at 11:12 AM, the Assistant Licensed Nursing Home Administrator (LNHA) stated in the presence of the survey team, the LNHA and the Corporate Clinical Officer (CCO) that it was correct the progress note was missing and should have been in the EMR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility's undated Charting and Documentation policy, included, All services provide to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. 3. All incidents, accidents, or changes in the resident's condition will be recorded as soon as physically as close to the occurrence as possible. 5. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: c. The assessment data. f. Notification of family, physician, or other staff, if indicated. NJAC 8:39-35.2 (d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 27193 Based on observation, interview, and record review, it was determined that the facility failed to adhere to accepted standards of infection control practices for the proper storage of respiratory tubing and mask after use for 2 of 2 residents reviewed (Resident #40 and #241). The deficient practice was evidenced by the following: 1. On 04/11/22 at 10:30 AM during the initial tour, the surveyor toured the subacute Unit and observed Resident #241 in bed, the head of the bed was elevated and the resident was resting with their eyes closed. The resident was receiving oxygen via a nasal cannula (tube inserted to the nose for oxygen delivery). The surveyor observed the Nebulizer mask (used for breathing treatments) directly placed on top of the night stand, touching the Nebulizer machine and in closed proximity of the resident's phone and toiletries items. The Nebulizer tubing was labeled and dated 04/11/24. On 04/12/24 at 9:45 AM, the surveyor returned to the room and observed that the Nebulizer mask was on the night stand as observed the day before. On 04/16/24 at 9:30 AM, the surveyor returned to the room and observed the Nebulizer mask directly placed on the night stand next to the Nebulizer machine. The surveyor observed the resident resting in bed. The surveyor attempted to interview the resident but the resident could not proceed with the interview. The surveyor returned to the room after the resident had been assisted with care and received morning medication and observed the Nebulizer mask on the night stand face down and not protected. The mask was dated 04/11/24. On 04/16/24 at 10:20 AM, the surveyor observed the Nebulizer mask still on the night stand, not protected and exposed to the environment. The surveyor accompanied the Infection Control Nurse Preventionist (IP) to the room where we both observed the Nebulizer Mask on the night stand and not protected. Upon inquiry, the IP informed the surveyor that the Nebulizer mask should have been placed inside a plastic bag when not in use to prevent infection. On 04/16/24 at 11:30 AM, review of the medical record reflected that Resident #241 was admitted to the facility with diagnoses which included, but were not limited to; acute respiratory failure with hypoxia, pneumonia unspecified organism. On 04/16/24 at 12:30 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the unit. She stated that after being used the Nebulizer mask should be stored in a plastic bag to prevent infection. A review of the Order Summary Report for April 2024, revealed the following orders for Resident #241: Ipratropium-Albuterol inhalation Solution 0.5-2.5(3)MG (milligrams)/ML (milliliter) Ipratropium-Albuterol 3 ml inhale orally 6 hours as needed for wheezing and shortness of breath. 2. On 04/11/24 at 10:35 AM, the surveyor entered Resident #40's room. The resident was not in the room. The surveyor observed the oxygen tubing and the nasal cannula on the bed. The oxygen tubing was not protected. Another nasal cannula was also noted on the night stand not protected. The nasal cannula on the night stand was not labeled/dated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same day at 12:11 PM, the surveyor returned to the room and observed a staff from physical therapy assisting the resident to the room. The staff assisted the resident to switch from the portable oxygen tank to the concentrator which was located behind the curtain next to the bed. The humidifier bottle was labeled and dated 04/11/24. The staff applied the nasal cannula that was noted on the bed. The staff used the nasal cannula that was left on the bed and not protected. On 04/12/24 at 8:30 AM, the surveyor returned to the room and observed the nasal cannula on the night stand as it was the day before, exposed to the environment. On 04/17/24 at 9:42 AM, the surveyor interviewed the LPN assigned to provide care to the resident. The LPN stated that all respiratory equipment including Nebulizer masks and oxygen tubing should be disinfected after use and placed in a bag to prevent infection. On 04/17/24 at 11:30 AM, the surveyor reviewed Resident #40's clinical record which reflected that Resident #40 had diagnoses which included but were not limited to; acute respiratory failure with hypoxia, pneumonia, emphysema and adult failure to thrive. The Order Summary Report dated April 2024, reflected an order for continuous oxygen at 2 liters per minute via nasal cannula with an original date of 03/27/24. The Order Summary Report also included an order to change and date oxygen tubing and humidification bottle (if in use) every night shift every on Wednesday for infection prevention. The order had an original date of 03/27/24 timed 23:00 [11:00 PM]. On 04/16/24 at 1:15 PM, the facility was informed of the above concerns and the surveyor requested the policy for oxygenation therapy. On 04/17/24 at 8:08 AM the facility provided an undated policy, titled, Respiratory Therapy Equipment Purpose The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. Steps 4 and 4 of the procedure indicated the following: 4. Change the oxygen cannula and tubing weekly and/or as needed. 5. Keep the oxygen cannula and tubing used PRN[as needed] in a plastic bag when not in use. Under Infection Control Considerations related to Medication Nebulizers/ Continuous aerosols the following were noted: After completion of therapy: Remove the Nebulizer container Rinse the container with fresh tap water; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dry on a clean paper towel or gauze sponge. Reconnect to the administration set-up when air dried. Wipe the mouth piece with damp paper towel or gauze sponge. Store in plastic bag. The policy was not being followed. NJAC 8:39-19.4 (a)1,2