STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315205	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Center for Rehab & Sub-Acute Care	Two Cooper Plaza Camden, NJ 08103

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43308 Based on interview and review of facility documentation, it was determined that the facility failed to issue the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and the Notice of Medicare Non-Coverage (NOMNC) for 1 of 3 residents (Resident #36) reviewed for Beneficiary Protection Notification. The deficient practice was evidenced by the following: The facility presented the surveyor with a list of residents who were discharged from the facility within six (6) months and should have received Beneficiary Notices. On 9/26/24 at 12:00 PM, the surveyor requested three (3) random residents', one (1) resident who went home and two (2) residents who remained in the facility, beneficiary notification forms from the Director of Nursing (DON). On 9/30/24 at 12:25 PM, the surveyor reviewed Resident #36's Beneficiary Notification list which indicated that the resident was discharged from a Medicare Part A stay at the facility and was documented as having a discontinuation of their Medicare Part A insurance payment to the facility. A review of the SNF Beneficiary Protection Notification Review (SNF BPNR) for Resident #36 indicated that the last covered day of Medicare Part A Service was 4/11/24. The SNF BPNR further revealed that a SNF ABN of non-coverage form CMS-10055 [CMS- the Centers for Medicare & Medicaid Services] and the NOMNC form CMS-10123 were provided to the resident. A review of the Advance Beneficiary Notice of Non-Coverage (ABN) form revealed Resident #36 did not sign the form. A review of the NOMNC revealed Resident #36 signed the form on 4/12/24, which was after the last covered day of Medicare Part A service. A review of the Progress Notes (PN) reflected on 4/12/24 at 5:30 PM from Social Services that a NOMNC was issued with the last covered date on 4/11/24, would revert back to Medicaid and no appeal. There was no documented evidence that the forms were provided to the resident prior to 4/11/24. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 9/30/24 at 12:36 PM, the Director of Social Services (DSS) in the presence of the survey team stated that she had been working at the facility for two (2) months but had seven (7) years of experience. The DSS stated that the SNF ABN and the NOMNC were given when therapy provide the last covered dates. She stated both forms should be given to the resident at least three (3) days prior to the last covered date. She further stated that if the resident could not sign the forms, then the resident's representative could sign it. The DSS explained the purpose of the forms were to inform the resident that their therapy was ending and if they would like to continue, the insurance would not pay and how much the resident would be responsible to pay. At that time, the surveyor and the DSS reviewed the provided NOMNC for Resident #36. She stated that the resident was admitted before she started at the facility. The DSS stated that the social worker (SW) was responsible for ensuring that the documents were signed. She stated that the previous SW made a mistake because the NOMNC was signed after the last covered day. She stated that it should have been signed prior to the last covered date. Upon review of the SNF ABN, the DSS stated that the ABN was not signed and acknowledged that it should have been signed. She stated that since the NOMNC was signed, the ABN should have been signed. She concluded if both documents were not signed, they are not aligned with what was told to the resident. On 9/30/24 at 1:37 PM, the DSS provided the guidelines the facility followed for the ABN and the NOMNC. At that time, the DSS stated that she followed up with the resident and that the SNF ABN form was not signed because prior to him/her signing anything the resident follows up with their [family representative]. The DSS stated that the facility did not have a policy, she just followed the CMS guidance. On 10/3/24 at 9:36 AM, the Regional Director of Nursing (RDON) stated in the presence of the Regional Licensed Nursing Home Administrator (Regional LNHA), the DON, the [NAME] President of Clinical Services (VPCS), and the survey team even though it was presented timely the resident does not sign anything until after the [family representative] reviewed it. At that time the RDON and the Regional LNHA acknowledged that the forms should have been signed prior to the last covered date. The RDON stated they would review the medical records to see if the prior SW documented that the forms were presented in a timely manner, but the resident did not want to sign until after the [family representative] knowledge of it. On 10/3/24 at 9:53 AM, the RDON stated that the facility did not have a policy related to SNF ABN and NOMNC and that they just followed the regulations. On 10/3/24 at 9:57 AM, the RDON stated they could not find any documentation that the resident was notified prior to the last covered date and that the resident wanted to wait to sign the forms. The RDON acknowledged both forms should have been signed prior and there should have been documentation. A review of the Social Services job description, updated October 2023, included, Main Duties: C. Maintain appropriate departmental documentation: c. record all significant events in resident's life and social service contacts. NJAC 8:39-4.1(a)(8)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40041 Based on interviews, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to ensure a) licensed staff credentials were verified upon hire (Staff #2 and #9), and reference checks were completed. This deficient practice was identified for 8 of 10 employee files reviewed (Employee #4, #6, #7, #8, #9 and #10) and was evidenced by the following: 1.) Staff #2, a Licensed Practical Nurse (LPN), with a date of hire 8/1/24, the employee file contained a copy of their licensure, however did not have a license verification printout in the employees file. There was no documented evidence that Staff #2's license was verified. Staff #9, an Occupation Therapist (OT), with the hire date 10/13/23, the employee file did not contain a copy of the license. In addition, there was no documented evidence that Staff #9's license was verified. 2.) A further review of the employee files for reference check reflected the following: Staff #4, a Licensed Practical Nurse (LPN), with a date of hire of 10/27/22, did not have a reference check on file. Staff #6, a Registered Nurse (RN), with a date of hire of 8/10/24, did not have a reference check on file. Staff #7, an LPN, with a date of hire of 6/27/24, did not have a reference check on file. Staff #8, a Certified Nurse Aide (CNA), with a date of hire of 7/6/23, did not have a reference check on file. Staff #9, an Occupation Therapist (OT), with a date of hire 10/13/23, did not have a reference check on file. Staff #10, a RN with the hire date of 5/16/24, did not have a reference check on file. On 10/1/24 at 2:34 PM, the Human Resource Director (HRD) reviewed the copy of Staff #2's State of New Jersey license with the surveyor and stated, I did not check this one because I have this here (pointing to the nursing license). The HRD confirmed that it was not verified that Staff # 2 had an active license. The survyeor continued to interview the HRD who stated that a copy of the licensure and a printout of the verification should have been included in the employees file. The HRD acknowledged that reference checks should have been completed and included in the employee files. On 10/2/24 at 1:41 PM, the Regional Director of Nursing (RDON) stated that all reference checks should be completed pre-employment. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Residents/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property undated policy, included .Screening Procedures A. Screening of all employees are screened prior to employment 2. Facility will be thorough in the investigation of past histories of individuals hired. This will be done through .c. References will be checked. NJAC 8:39-4.1(a)5

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40041 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop a comprehensive person-centered care plan for 1 of 24 residents (Resident #26) reviewed. This deficient practice was evidenced by the following: A review of the Admission Record (an admission summary) revealed Resident #26 had diagnoses which included, but were not limited to, open wound left foot, non-pressure chronic ulcer of other part of left foot, acute osteomyelitis, Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia, Anxiety Disorder, Major Depressive Disorder, and Post Traumatic Stress Disorder Upon review of the Electronic Medical Record (EMR), there was no evidence that the Comprehensive Care Plan was completed. On 10/01/24 at 1:18 PM, during surveyor interview, the Unit Manager (UM) pulled up the EMR for Resident #26 and confirmed that the Comprehensive Care Plan was not completed. The UM stated that the Comprehensive Care Plan should have been completed to ensure that staff knows how to better assist the resident. A review of the facility policy titled, INTERDISCIPLINARY CARE PLANNING PROTOCOL .1. Social Services provides overview of social history and needs 2. Nursing provides overview of medical and nursing care regimens. Nursing assistants must provide input especially related to ADL (activities of daily living), skin, weights, and safety needs. 3. Activities and Dietary provide an overview of their assessment of residents needs and problems. 4. Other disciplines provide input as appropriate . NJAC 8:39-11.2(3)h

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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. 37547 Based on observations, interviews, and review of other pertinent documentation, it was determined that the facility failed to administer medications in accordance with physician's orders and professional standards of nursing clinical practice. This deficient practice was identified during the medication pass observation for 1 of 2 nurses on 1 of 2 nursing units (Two West). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, 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 tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 09/27/24 at 8:49 AM, the surveyor observed Licensed Practical Nurse (LPN) #5 as she prepared and administered six oral medications and a steroidal (steroid) inhaler (fluticasone propionate and salmeterol 232 mcg/14 mcg, a combination of two medications used to help control the symptoms of asthma and improve breathing) to Resident #92. At 8:59 AM, the surveyor observed LPN #5 provide Resident #92 with the fluticasone propionate and salmeterol 232 mcg/14 mcg inhaler, without instruction. The resident then proceeded to take one puff of the inhaler. LPN #5 then handed the resident a medication cup that contained the resident's scheduled medications and a cup of water. The surveyor observed the resident who took the medications with sips of water, but did not drink all of the water that was provided. LPN #5 stated I gave the resident the inhaler first, then the oral medications were given with water, that way the resident rinsed their mouth after. At that time, LPN #5 asked Resident #92 if he/she had any pain? The resident stated, Yes. LPN #5 asked the resident to rate their pain on a scale from 0 to 10 (ten) with ten being the worst pain. Resident #92 stated that their left lower leg pain was rated as a six. LPN #5 then proceeded to review the resident's pain medication orders and stated that the resident had an order for Acetaminophen (pain reliever) 650 mg (milligrams). LPN #5 stated that the full dose was not available on her cart and then proceeded to go to the medication room, and then to another medication cart to obtain a stock medication bottle of the full dosage of acetaminophen (two 325 mg tablets). At 9:14 AM, LPN #5 administered Acetaminophen 650 mg to Resident #92 and stated that the medication was given for a pain level of six out of ten. A review of Resident # 92's Admission Record (an admission summary) which revealed that Resident #92 was admitted to the facility with diagnosis which included but were not limited to: pain, unspecified, opioid use, unspecified, uncomplicated, other psychoactive substance abuse, uncomplicated, anxiety disorder, unspecified, and other abnormalities of gait and mobility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of resident #92's Quarterly Minimum Data Set (MDS), an assessment tool, revealed that the resident had a Brief Interview for Mental Status Score (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. A review of Resident #92's Order Summary Report (OSR) revealed an order dated 07/18/24, for Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 232-14 MCG (micrograms) . (Fluticasone-Salmeterol) 1 (one) puff inhale orally two times a day for dyspnea (trouble breathing) 1 (one) puff twice daily, rinse mouth after use. A second order dated 05/21/24, was noted for Acetaminophen Tablet 325 mg Give 2 (two) tablets by mouth every 6 (six) hours as needed for mild pain 1 (one)- 4 (four). Do not exceed 3 GM (grams) (3,000 mg) Acetaminophen in 24 hours form [sic.] all sources 2 (two) tabs=650 mg. Further review of the OSR revealed that there was not a second order in place to address the resident's pain level if it were greater than four. On 09/27/24 at 9:29 AM, during a later interview with LPN #5 she stated that the purpose of having a resident rinse their mouth after an inhaler such as Fluticasone-Salmeterol were administered was to protect the gums and teeth. LPN #5 further stated that the resident was allowed to swallow after they rinsed their mouth, rather than spit it out. At 9:30 AM, the surveyor asked LPN #5 to review Resident #92's Acetaminophen order on the Medication Administration Record (MAR). LPN #5 stated that the order was for mild pain on a 1 (one) to 4 (four) pain scale. LPN #5 stated that we normally give this one and use our judgement whether or not to call the doctor. LPN #5 further stated, If no relief, I call the doctor. During an interview with the surveyor on 09/30/24 at 12:26 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that for Fluticasone-Salmeterol inhaler she would have the resident rinse their mouth and spit after administration to prevent oral thrush (a fungal infection that can affect the mouth). The LPN/UM stated that drinking water with pills does not take the place of rinsing and spitting because they are taking their medications. At that time, the surveyor asked the LPN/UM if it were permissible to administer Acetaminophen 650 mg orally prescribed for mild pain 1 (one) to 4 (four) for a pain level of six out of ten? The LPN/UM stated that the nurse should have seen if something else was ordered first, to determine if there was something for a pain scale higher than four out of ten. The LPN/UM stated if not, then I would call the doctor to see if he wanted me to give it, or order something else. During an interview with the surveyor on 09/30/24 at 1:02 PM, the Consultant Pharmacist (CP) stated that the type of mouth care direction provided to residents depended on the type of inhaler. The CP stated that as long as the inhaler was steroidal, then the residents were supposed to rinse and spit to avoid oral thrush. The CP further stated, Fluticasone propionate and salmeterol was a steroidal inhaler and they are supposed to rinse and spit after to avoid oral thrush. At that time, the CP stated that if Acetaminophen were ordered for a pain level of 1 (one) - 4 (four), and the resident's pain level was six and no other prn (as needed) medication were ordered, then the nurse should notify the MD (medical doctor) of the resident's pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/01/24 at 10:54 AM, the Director of Nursing (DON) stated that with inhaler usage, such as fluticasone propionate and salmeterol, you have to rinse the mouth and spit it out to prevent oral thrush or candida (fungal infection). The DON stated that the nurse should give directions. The DON stated that you can not assume that drinking water would rinse the mouth. At that time, the DON stated that the nurse should have contacted the doctor if the resident were actively in pain, to do something for the pain, to get something supplemental. The DON stated that the nurse could have contacted the doctor first, to inform him, and let the doctor know for further clarification. A review of the facility policy, Medication Administration Policy (02/24) revealed the following: The facility shall administer all resident medications according to physician orders. .PRN medications should be given according to physicians order and documented on the MAR under date given, time noted and nurses initials. Reason for administration must be documented on the MAR, as well as result, where applicable. NJAC 8:39-11.2(b), 29.4 (b) (2), 27.1(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37547 Based on observation, interviews, record review and review of other pertinent information, it was determined that the facility failed to ensure dietary assessments were conducted in a timely manner for a resident with a feeding tube who experienced weight loss. This deficient practice was identified for 1 of 1 resident (Resident #27) reviewed for tube feeding. This deficient practice was identified by the following: On 09/27/24 at 12:57 PM, the surveyor observed Resident #27 lying in bed awake. The resident had a tube feeding (artificial nutrition delivered through a tube that is surgically inserted into the stomach) pump that hung on a pole beside the resident's bed that was not in use at the time of the observation. A review of Resident #27's Admission Record (an admission summary) revealed that the resident was admitted to the facility with a past medical history of cerebral infarction, unspecified (stroke), unspecified speech disturbances, dysphagia, unspecified (swallowing disorder), unspecified protein-calorie malnutrition and schizophrenia (psychiatric disorder). A review of Resident #27's Quarterly Minimum Data Set (MDS), an assessment tool, dated 07/19/24, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that the resident was severely cognitively impaired. Further review of the MDS indicated that the resident had a feeding tube and had not experienced a weight loss or weight gain of 5 (five) % or more in the last month or a loss of 10 (ten) % in the last six months. A review of Resident #27's Care Plan revealed an entry dated 04/17/24, with revision on 05/15/24, with a Focus of: Resident #27 has a nutritional problem r/t (related to) aspiration pneumonia (a lung infection due to a relatively large amount of material from the stomach or mouth entering the lungs) and NPO (nothing permitted orally) due to dysphagia requiring tube feeding to meet his/her needs, with refusal of his/her tube feedings. Goal: Resident #27 will not have a significant weight change and Resident #27 will not experience aspiration, malabsorption, or decline in nutritional status. Interventions included but were not limited to: .Tube feeding and water flushes as ordered and weight as ordered. A review of Resident #27's Order Summary Report revealed an order dated 09/26/24, for NPO diet, and Jevity 1.5 at 70 ml (milliliters) per hour for TV (total volume) of 1,300 ml till total volume infused via pump in the evening for tube feeding up at 6 PM. A second order dated 04/17/24, was noted for a Monthly weight each month. A review of Resident #27's Nutritional Evaluation, dated 04/17/24 at 18:19 (6:19 PM), indicated that the resident's most recent weight on 04/04/24 was 137.2 lbs, and the resident's usual body weight was 135 lbs. Further review of the resident's EHR revealed that there were no quarterly or annual nutritional evaluation completed thereafter. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #27's EHR (electronic health record) revealed a Nutrition/Dietary Note dated 05/15/24 at 21:31 (9:31 PM), which was documented by the former Dietician and indicated that the resident's weight on 05/15/24 was 130.4 lb (pounds) and reflected a 6.5 lb weight loss since 04/04/24 (137.2 lbs) .Further review of the entry revealed the following, Spoke to nursing who reports resident has been refusing his/her tube feeding to be hung at his/her scheduled times, and weight loss may be related to resident's refusal of his/her tube feedings .Will increase total volume to increase calories due to weight loss and start tube feeding at a later time in the day. Will order Jevity 1.5 at 70 ml/hour, up at 6 PM, for TV=1,300 ml, .Will follow-up. Further review of the Progress Notes revealed that there was no further documentation to reflect that the Dietician followed up on the resident's nutritional status as indicated. A review of Resident #27's last recorded weight under the weights/vitals tab in the EHR revealed that on 09/05/24, the resident weighed 139 lbs. During an interview with the surveyor on 10/01/24 at 10:19 AM, the Dietician stated that she had worked at the facility since June 2024. The Dietician stated that she saw Resident #27, but sometimes started something, then went onto something else and failed to complete the task. The Dietician stated that the resident was due for a Nutritional Assessment on 07/19/24, and she did not get to do it. The Dietician stated that she reviewed the resident's weights but did not document that she reviewed them. The Dietician stated that she worked at the facility 24 hours per week, which was not enough time to get all of my work done. The Dietician stated that she reported to the Licensed Nursing Home Administrator (LNHA) that she was not able to get her work done in the time allotted and he stated that the position was only for 24 hours per week. The Dietician stated, that was the reason why the resident had not received a formal assessment. The Dietician then stated, I just did a note now. The Dietician stated that there were 113 residents in the facility, and she received a lot of admissions and had to do their admission assessments. The Dietician stated that the resident had a significant change assessment (completed when a change in status was observed to drive care) completed on 07/19/24 by MDS Coordinator and a quarterly nutritional assessment was not done and was not completed on schedule. The Dietician stated that the importance of doing a quarterly assessment after a significant change was to follow up on the resident's significant change and write a follow-up note. The Dietician further stated, The resident's doing better, thank God. During an interview with the surveyor on 10/01/24 at 11:25 AM, the Director of Nursing (DON) stated that weekly weight meetings were held with the Dietician and the Interdisciplinary Team. The DON stated that they notified the doctor and the resident's family. The DON stated, There are notes in there. The DON stated that she thought the Dietician was required to complete quarterly nutritional assessments, but was not sure. During an interview with the surveyor on 10/01/24 at 11:30 AM, the MDS Coordinator (MDSC) stated that he had worked at the facility since April of 2024 and this was his first position as an MDSC. The MDSC stated that he initiated a significant change assessment for Resident #27 on 04/22/24, after the resident had a decline in their ADLs (activities of daily living) post-hospitalization . The MDSC stated the resident's last quarterly MDS was completed on 07/19/24, and the Dietician note that was included in the Nutritional portion of the MDS was written by the current Dietician. The MDSC stated, sometimes there were no notes in the EHR by the Dietician. The MDSC stated that he reviewed the Dietician's notes and conferred with the Dietician when there were no notes seen. The MDSC further stated, There should be Dietician documentation, but I do not see anything there. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/01/24 at 12:13 PM, the LNHA stated that the Dietician was hired for 24 hours per week, and if she needed more time, she may request more time. The LNHA stated that the Dietician completed an admission assessment, quarterly assessments, and as needed. The LNHA stated, Yes, naturally there should be documentation on a tube fed resident. He stated, There was always enough time. The LNHA further stated, The previous Dieticians were able to do it in time. The surveyor requested a copy of the facility policy related to the Dietician's required documentation and the facility was unable to provide the policy when requested. A review of the Job Description (Revised 11/26/10) of the Dietician revealed the following: Position: Dietician Reports to: administrator Job Responsibilities: Develop preliminary and comprehensive assessments of the dietary needs of each resident throughout their stay. Review and revise care plans and assessments as necessary, but at least quarterly. NJAC 8:39-17.1(c), 17.2(c), (d)

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Majestic Center for Rehab & Sub-Acute Care	Two Cooper Plaza Camden, NJ 08103

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41072 PART A: NJ Complaint #: 163766 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to (a) ensure there was emergency tracheostomy equipment for a resident with a tracheostomy (a surgical opening in the neck to provide an airway and remove secretions from the lungs), and (b) ensure staff were trained to use the emergency equipment in case of displacement of the tracheostomy tube for one (1) of 1 resident (Resident #313) reviewed with a tracheostomy. Resident #313 was admitted to the facility with a tracheostomy (trach). A review of the Progress Notes revealed that the resident was sent to the hospital on two occasions, on 03/30/23 for not having tracheostomy supplies, and on 04/6/23 for decannulation (removal) of the trach. During an interview with the surveyor, the pulmonologist stated that the resident was admitted to the facility without the proper tracheostomy supplies (inner cannula, ambu bag, and an extra trach) and if the tracheostomy came out, there was no replacement, and that the facility did not know when the supplies would arrive. The pulmonologist sent the resident to the hospital twice on 03/30/23 and on 04/6/23 because there were no supplies for the resident. The surveyor interviewed LPN #1 who stated she cared for Resident # 313 but did not have education for taking care of a resident with a trach. She further stated that there were no tracheostomy supplies at the bedside or at the facility. The facility's failure to ensure there was emergency equipment in the resident's room and failure to ensure staff were trained to use the emergency equipment in case of the displacement of the tracheostomy tube placed the resident at risk for serious harm, serious impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 03/23/23 when the resident was admitted to the facility and was transferred to the hospital on 03/30/23 and 04/6/23 because there were no tracheostomy supplies at the bedside or in the facility in addition to ensuring that all staff caring for Resident #313 were trained. The Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPO), the Director of Nursing (DON), the Regional DON (RDON), and the [NAME] President of Clinicals Services (VPCS) were informed of the IJ on 09/30/24 at 4:58 PM. The facility submitted an acceptable Removal Plan (RP) on 10/1/24 at 1:00 PM. The survey team verified the implementation of the (RP) during the continuation of the on-site survey on 10/1/24. The evidence was as follows: (continued on next page)

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F 0695 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 undated Tracheostomy Care policy revealed Tracheostomy care and suctioning shall be performed as necessary to maintain a clear airway and to prevent infection. The purpose of tracheostomy care is to maintain a patent airway; to keep the tracheostomy area clean and free of irritation and infection; and to prevent the tracheostomy tube from being coughed or pulled out. Equipment needed included but not limited to a. oxygen set up including oxygen concentrator, oxygen humidifier bottle, oxygen flow meter, oxygen tubing/trach collar, b. Suctioning set up including portable suction machine, sterile tracheostomy care tray, suction gauge, sterile Sodium Chloride irrigation and c. Other: stethoscope, sterile disposable suction catheter kits for PRN (as needed) suctioning and replacement inner cannulas. The policy further indicated under SPECIAL NOTE: 1. Never remove outer cannula: this is changed only by a Physician and 2. Be careful not to dislodge the Tracheostomy Tube. On 09/30/24, the surveyor reviewed the closed record of Resident #313. A review of the Admission Record documented that Resident #313 had diagnoses which included, but were not limited to, acute respiratory failure with hypoxia (low levels of oxygen in your body tissues), tracheostomy (trach), asthma, cocaine abuse, alcohol dependence, and homelessness. The admission Minimum Data Set (MDS), an assessment tool, dated 03/29/23, reflected the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The MDS further indicated that the resident had a tracheostomy and received oxygen and suctioning. A review of Resident #313's Care Plan, initiated on 03/24/23 and revised on 04/06/24, included a focus for a tracheostomy related to acute respiratory failure with interventions that included to ensure trach ties were secured at all times, monitor/document for restlessness, agitation, confusion, increased heartbeat and bradycardia (decreased heart rate), good oral care and suction as necessary. The surveyor reviewed Resident #313's physicians orders (PO) dated 03/24/23 with a discontinued date of 04/18/23, which included the following: Give oxygen @(specify) via trach, mask continuous with (specify)% humidified air every shift for trach care. Suction tracheostomy tube as needed for patency or to keep the airway open. Suction tracheostomies tube every shift for patency or to keep the airway open AND as needed for patency or to keep the airway open. Tracheostomy Care every shift every shift for Trach Care. Tracheostomy care every shift as needed. Tracheostomy Size: 7.5 every shift for Tracheostomy Monitoring. (continued on next page)

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F 0695 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 Admit/Readmit Evaluation Assessment, dated 03/23/23 at 22:20 (10:20 PM), revealed that Resident #313 had an occasional cough and a tracheostomy size 7.5 cuffed. The nurse did not document if the resident was on oxygen, or if the resident had a trach collar (a soft plastic mask that fits over the trach to deliver humified air or oxygen directly to the trach) or humidification. A review of the admitting nurse (LPN #6) admission summary dated 03/23/23 at 22:40 (10:40 PM), revealed that Resident #313 was admitted to the facility with a 7.5 sized trach .able to make needs known by writing on the dry erase board, and call bell within reach and uses it frequently. A review of the Pulmonary Advanced Practice Nurse (APN #2) PN, dated 03/30/23 at 14:00 (2:00 PM), revealed that the resident was sent to the emergency room (ER) as the facility did not have equipment available for the resident's trach care and was unsure when they would get it [no ambu bag (a device used to provide respiratory support to patients in emergency and non-emergency situations), no inner cannula (a tube within the outer tube which can be removed and cleaned easily, without having to change the whole, outer tracheostomy tube), and no replacement trachs]. The progress notes also revealed that the case was discussed with nursing, and the primary care team were aware of the plan. A review of a nurse's note, dated 03/30/23 at 14:00 (2:00 PM), revealed that the resident was sent to the emergency room (ER) to replace the resident ' s trach inner cannula with a size 7.5. APN #2 saw the resident at the bedside and agreed for the resident to be sent to the ER. A review of the APN #2's Physicians Order, dated 03/31/23, revealed the following: Tracheostomy Type: [Name redacted] trach Size:8UN85H Routine trach care daily and as needed, change fastener weekly, and please order 3 appropriately sized tracheostomies to keep at the bedside, I will change the trach at my next visit. Please also order a box of appropriately sized inner cannulas to keep at the bedside. A review of a nurses note dated, 04/05/23 at 21:31(9:31 PM), revealed that the resident was sent to the ER for decannulation (removing) of the trach. A review of a PN that was written by the APN #2, dated 04/06/23 (late entry), reflected that a call was placed to the nursing supervisor at the acute hospital and supplies were obtained for the bedside by that provider. The progress notes also revealed that the case was discussed with nursing and primary care team aware of plan. On 09/30/24 at 12:55 PM, the surveyor interviewed LPN #4 who stated she had been employed at the facility for about a year and had not had a resident with a tracheostomy. LPN #4 stated that a resident admitted with a tracheostomy would need supplies kept at the bedside that would include oxygen set up, suction machine, extra tracheostomies, trach ties, and drain sponge pads. LPN#4 further stated that the Unit Manager (UM), Director of Nursing (DON) or admitting nurse would be responsible to make sure all equipment and supplies were in the resident's room before the resident was admitted . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 09/30/24 at 12;43 PM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who had been employed with the facility since July 2024 who stated she had not had an admission with a tracheostomy. The LPN/UM further stated that a resident who had a tracheostomy should have the following supplies and equipment at the bedside: a compressor, oxygen set up, suction machine, ambu bag, trach supplies including trach collars, suction catheters, drain sponges, and extra trachs and inner cannulas in case of an emergency and that the Unit Manager would be responsible to ensure all trach supplies and equipment were in the resident's room prior to admission. The LPN/UM further stated that if they needed any supplies, they would notify Central Supply (CS). On 09/30/24 at 1:17 PM, the surveyor interviewed the Admissions Coordinator (AC) who stated she was previously an external liaison, but for the past two weeks has been employed as the AC. The AC stated that when a resident was admitted to the facility with a tracheostomy, the external liaison would provide the admissions director with the size of the trach and any oxygen requirements, then admissions would notify the unit and make sure the facility had all the necessary equipment needed prior to admission which would include; trach size, suction machine, oxygen tubing, and an ambu bag at the bedside. The AC added, I am not sure if respiratory or nursing would set up the room. On 09/30/24 at 1:33 PM, the surveyor conducted a telephone interview with the attending physician (MD) who reviewed the progress notes written by APN #1. The MD then reviewed the APN #2's note from 03/30/24 and stated he was not aware that APN #2 documented that the trachs, inner cannulas, or ambu bag were not at the bedside. The MD further stated that the facility usually would have supplies and equipment at the bedside for emergencies. The MD stated he would further review the medical records and call the surveyor back with any further information. The surveyor did not receive a return call from the MD. On 09/30/24 at 2:08 PM, the surveyor conducted a telephone interview with APN#2 who stated that Resident #313 was admitted to the facility without the proper trach supplies (inner cannula, ambu bag and extra trachs) and if the trach came out there would be no replacement at the bedside and at the facility. APN#2 stated the reason she sent Resident #313 to theER on [DATE] was because the facility did not have the supplies at the facility and did not know when they would get the supplies. APN #2 stated she saw the resident again on 04/06/23 and the trach supplies were still not at the bedside (extra trachs and inner cannulas). APN #2 further stated she had notified the nurse at the desk but did not remember their name and notified the nursing supervisor. APN #2 stated that she spoke with the nursing supervisor at the acute hospital and told them that the resident was sent back from the ER without a spare trach or inner cannulas and either they provide the supplies, or she was sending the resident back to the ER. APN #2 stated she obtained the extra trachs and inner cannulas from the acute hospital and placed them at the resident's bedside. APN #2 further stated that it was important for a resident with a trach to have extra trachs and inner cannulas at the bedside because if the trach got plugged you need to take out the inner cannula and replace it or if the trach comes out you need another trach to put in for airway protection. On 09/30/24 at 2:47 PM, the surveyor interviewed the DON who stated she has been employed at the facility since May 2023 and confirmed that the facility had not admitted a resident with a tracheostomy since Resident # 313. The DON further stated that a resident admitted with a trach should have all supplies and equipment at the bedside prior to admission which includes: oxygen, suction machine, trach sizes (one up and one down sized trach) ambu-bag, inner cannulas, and drain sponges. The resident should have what they need prior to admission, or we shouldn't admit them. The DON further stated, The importance of having all supplies at the bedside is to prevent respiratory distress. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 09/30/24 at 3:06 PM, the surveyor conducted a telephone interviewed with LPN # 1 who stated that she was an agency nurse who worked the 11 PM to 7 AM shift when Resident #313 was admitted to the facility. LPN #1 further stated that she had not received education for tracheostomy care through her agency or the facility. LPN #1 stated, I remember that situation, because it was crazy. LPN #1 stated that when the resident was admitted to the facility, the room was not set up with supplies for a resident with a trach. LPN #1 stated the first night the resident came in we did not have anything, and I did not have a key to get anything. LPN #1 stated that the resident needed a suction canister, the cleaning thing for the resident ' s trach but there wasn't anything. LPN #1 stated that she was scrambling for supplies. LPN #1 stated, I remember [the resident ' s] trach was a 7.5, but I did not have any extra trachs or inner cannulas. LPN #1 stated that she had to set up the oxygen and use an oxygen mask over the trach because we did not have a trach collar mask. LPN #1 stated, This was my first trach patient ever, and we did not have the inner cannulas. LPN #1 further stated the next morning she stayed and told Central Supply (CS) that the supplies were needed. LPN #1 further stated that the second night on the 11 PM to 7 AM shift, she called a nurse from the second floor (LPN #2) who came to the unit and helped her to get all the supplies that were needed and set up the resident's room. LPN #1 stated, We had everything except the extra trachs and inner cannulas. She further stated, We needed the inner cannulas to take them in and out and we never got them. I remember the resident was having trouble breathing and I took out the inner cannula and it was dry. I had to clean it and put the same one back in. We had to keep cleaning the one (same) inner cannula we had when [the resident] came from the hospital. On 10/01/23 at 9:01 AM, the surveyor interviewed the CS staff who stated he had worked in central supply for about 5 years. The CS staff stated that admissions, the DON, or the UM were supposed to notify him prior to admission if a trach resident was to be admitted . The CS stated, Yes, I remember Resident #313. I was notified by admissions on the day [the resident] was admitted but I had already left for the day. He explained admissions notified him through [name redacted - a free, cross-platform messaging service application], the facility used when he was already at home. The CS stated, I had all the supplies in central supply including suction machine, tubing, concentrator, water, trach size #4 or #6. If I'm not here to set up the room with the supplies, it's up to the nurses to get the supplies. I may not have had the inner cannula tubes, but I had all the other supplies. I remember what I had in stock at that time trach #4, #5 and #6 and I think the resident had a #4 trach. I came in the next morning and brought all the trach supplies to the resident's room. On 10/01/24 at 1:53 PM, the surveyor conducted a telephone interview with LPN #6 who stated she was an agency nurse who had admitted Resident #313 on the 3 PM to 11 PM shift. LPN #6 stated yes, I remember that resident. The facility had trach sizes in house but not his size and that was an issue. The inner cannula was the wrong size. We did not have [the resident's] size inner cannula in the facility, we had smaller trachs but not the resident's size. LPN #6 further stated the facility was not prepared to take care of a trach patient; no one knew what to do with the resident. LPN #6 stated she did not receive education regarding trach care at the facility but had worked previously with trachs and ventilators at other facilities. LPN #6 concluded I feel the staff were afraid to take care of a trach. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/01/24 at 2:23 PM, the surveyor conducted a telephone interview with Resident #313's family representative (FR). The FR stated that when the resident was admitted to the facility, the facility had very little supplies and they were trying to get all the supplies that was needed. The FR further stated the facility did not have any inner cannulas and that they did not have the staff to do what needed to be done. The facility provided copies of Tracheotomy Care Competency skills list for LPN #1 and LPN #2. LPN #1 Tracheostomy Care Competency Skills Checklist was signed and dated as completed on 12/6/22. LPN #2's Tracheostomy Care Competency Skills Checklist was signed as completed on 11/09/23, after the resident was discharged . The surveyor requested to review the original, not copies, of the competencies for both LPNs but the facility was unable to provide the original checklists. An acceptable RP was received on 10/01/24 at 11:31 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: 1.) The DON conducted a house wide audit on 09/30/24 to resident physician orders and identified no additional residents with a trach were at the facility; 2.) The Assistant DON (ADON) completed education and in-servicing for all licensed staff on the location of trach supplies at the bedside and in the facility and to communicate the need for additional supplies on trach care and on trach care emergencies; 3.) the Pulmonologist was re-educated to inform the DON for trach supply related concerns should they arise in the future. The survey team verified the implementation of the removal plan during the continuation of the on-site survey on 10/01/24. The surveyor had requested the following information from 9/27/24 through 10/3/24: Staffing and assignments for the dates of 03/23/023 through 04/06/23; tracheostomy education or competencies for all staff who worked with Resident #313 from 03/23/23 through 04/06/23; timeclock/time sheets for the dates of 03/25/23 through 04/06/23; paper medical records that were not scanned into the electronic medical record, including after visit summaries from Resident #313's ER visits. On 10/03/24 at 10:45 AM, and the facility confirmed they were unable to provide the requested information. F695 remains a deficiency at a scope and severity of a D based on the following: PART B The facility further failed to (c) consistently document in the Medication Administration Record (MAR) and Treatment Administration Record (TAR) that oxygen and respiratory related treatments were administered as ordered, (d) clarify physician orders for a resident with a tracheostomy, and (e) ensure that physician orders were accurately transcribed and followed for 1 of 4 residents (Resident #313) reviewed for respiratory care. (continued on next page)

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F 0695 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 March 2023 and April 2023 Order Summary Report and the March 2023 and April 2023 MARs and TARs for Resident #313 revealed that there was no documentation to indicate that the medications and treatments were administered as ordered on the following dates and times: 1.Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 3 ml inhale orally via nebulizer two times a day for SOB (shortness of breath)-Ordered 3/24/2023 0900 3/24/23, 04/9/23 2100 - 03/26/23, 04/6/23, 04/11/23, 04/12/23, 04/14/23 2. Acetylcysteine Solution 20 % 2 milliliter inhale orally every 12 hours for mucous secretions- Ordered 03/23/2023 0900- 03/24/23 2100-03/23/23 04/3/23, 04/06/23, 04/11/23, 04/12/23, 04/14/23 3. Give O2 @ (specify)via trach. mask continuous with (specify) % humidified air every shift for Trach Care-Ordered 03/24/23. Day shift- 03/28/23,03/29/23, 03/30/23 04/01/23, 04/05/23, 04/07/23, 04/12/23, 04/13/23, 04/14/23 Evening shift- 3/26/24, 3/27/24,3/30/24, 04/06/23, 04/10/23, 04/11/23, 0412/23, 04/13/23, 04/14/23, 04/17/23 Night shift 03/28/23, 04/08/23 4. Suction tracheostomy tube every shift for patency or to keep the airway open-Ordered 03/24/2023 Day shift-3/29/23, 03/30/23, 04/07/23. 04/12/23, 04/13/23, 04/14/23, 04/17/23 Evening shift-3/26/23, 03/27/23, 03/30/23, 04/06/23,04/10/23. 04/11/23, 04/12/23, 04/13/23, 04.14/23, 04/16/23 Night shift-3/28/24, 04/11/23 5.Tracheostomy Care every shift. every shift for Trach Care-Ordered 03/24/2023. Day shift-3/29/23, 03/03/30, 04/1/23, 04/07/23, 04/13/23, 04/14/23, 04/17/23 Evening shift-03/26/2, 03/27/23. 03/30/23, 04/6/23, 04/10/23, 04/11/23, 04/12/23, 04/13/23. 04/14/23, 04/16/23 Night shift-3/28/24, 04/10/23 (continued on next page)

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F 0695 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 Advanced Practice Nurse (APN #1) Progress Note (PN), dated 03/27/23 at 12:35 PM, revealed documentation of shortness of breath and to continue supplemental oxygen. There was no documentation of the trach size, oxygen liters and delivery method, or amount of oxygen humidification. This note was signed by the attending Medical Doctor (MD) on 04/01/23 at 11:19 PM. A review of the Pulmonary Advanced Practice Nurse (APN #2) PN, dated 03/30/23 at 14:00 (2:00 PM), revealed under the assessment and plan section, APN #2 documented to continue oxygen; monitor SpO2 (oxygen saturation); avoid hyperoxia (high oxygen levels); tracheostomy present *8UN85H (trach tube flexible cuffless 8.5 millimeter); tracheostomy care BID (twice a day), change tracheostomy every 8 weeks-next due on 05/01/23 and Humidified oxygen via TC (trach collar) at 38%. The progress notes also revealed that the case was discussed with nursing, and the primary care team were aware of the plan. A review of the March 2023 active physician's orders did not reflect a change in the PO to a Trach size of #8UN85H or the recommended oxygen and humidification. A PN that was written by the APN #2, dated 04/06/23 (late entry), reflected to continue oxygen; monitor SpO2 (oxygen saturation); avoid hyperoxia (high oxygen levels); tracheostomy present *8UN85H (trach tube flexible cuffless 8.5 millimeter); tracheostomy care BID (twice a day), change tracheostomy every 8 (eight) weeks-next due on 05/01/23 and Humidified oxygen via TC at 38%. The progress notes also revealed that the case was discussed with nursing and primary care team aware of plan. A review of APN #2's PO, dated 04/06/23, reflected the following: Please put patient on a humidified trach collar TODAY. Please have 3 (three) #6UN75h trachs at bedside. Please place 1 (one) box of appropriately sized inner cannulas at bedside. Trach care BID and as needed. Weekly trach tie changes. I will change the trach every 8 weeks while the patient is admitted . Suction PRN two times a day for trach care BID. A review of the April 2023 active physician's orders did not reflect a change in the PO to a trach size of #8UN85H or the recommended oxygen and humidification. A nurses note, dated 04/06/23 at 13:49 (1:49 PM), revealed that Resident #313 returned form the acute hospital with no new orders or discharge paperwork. The nurse called the hospital to see if the paperwork could be forwarded. A review of the sending hospital after visit summary and medical records from Resident's #313's acute hospitalization from [DATE] through 03/23/23 did not reveal any documentation of the size tracheostomy, oxygen or if humification was recommended. The following physicians order for oxygen were not clarified or transcribed during Resident#313's admission to the facility from 03/23/23 to 04/18/23: 1.Give O2 @ (specify)via trach. mask continuous with (specify) % humidified air every shift for Trach Care-Start Date 03/24/2023 0700-Hold Date from 04/05/2023 2135 to 04/06/2023 1347-Hold Date from 04/08/2023 1439 to 04/09/2023 2213-D/C Date 04/18/2023 0112. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. [Name redacted] Size:8UN85H Routine trach care daily and as needed, change fastener weekly, and please order 3 appropriately sized tracheostomies to keep at the bedside, I will change the trach at my next visit. Please also order a box of appropriately sized inner cannulas to keep at the bedside. [NAME] one time a day for trach care. Ordered 03/31/23. 3. Please put patient on a humidified trach collar TODAY Please have 3 6UN75h trachs at bedside Please place 1 box of appropriately sized inner cannulas at bedside Trach card BID an as needed Weekly trach tie changes I will change the trach every 8 weeks while the patient is admitted Suction PRN two times a day for trach care BID. Ordered 04/06/23. On 10/01/24 at 10:18 AM, the surveyor interviewed LPN #3 who stated that when administering medications or treatments, the nurse should sign out the medications after they were given or completed and there should not be any blanks (not initialed as given) on the MAR or TAR. If there were blanks on the MAR or TAR it could mean that the nurse forgot to sign it out or forgot to do it. LPN #3 further stated If it wasn't documented, it wasn't done. LPN #3, in the presence of the surveyor, reviewed the oxygen Physician Order (PO), dated 03/23/23, and stated that the PO should have a specific number of liters of oxygen to be given and how the oxygen should be given. It was important to have a PO for oxygen because oxygen was a medication that needed to be prescribed by the doctor. When asked how the nurse would know how much oxygen to provide to Resident #313 with the PO as written, LPN #3 stated the nurses wouldn't know by that order. On 10/01/24 at 10:36 AM, the surveyor interviewed the LPN/UM who stated that all medication and treatment should be signed out as soon as they were administered. If there are blanks on the MARs and TARs, it was not done. The LPN/UM stated, If it's not documented, then it is not done. The LPN/UM further stated that if the resident was in the hospital, out of the facility or refused, there was a space to document why the medication or treatment was not given and there should not be any blanks in the MARs and TARs. At that time, the LPN/UM and the surveyor reviewed the above oxygen order dated 03/23/23 and the LPN/ UM stated that the order was an incomplete PO because it did not include how many liters of oxygen and the percentage of humified oxygen to administer to the resident. She further stated that the nurse should have called the doctor and clarified the oxygen order because oxygen was a medication. The LPN/UM, in the presence of the surveyor, reviewed the PO's as written below: 1.Please put patient on a humidified trach collar TODAY Please have 3 6UN75h trachs at bedside Please place 1 box of appropriately sized inner cannulas at bedside Trach card BID an as needed Weekly trach tie changes I will change the trach every 8 weeks while the patient is admitted Suction PRN two times a day for trach care BID. Ordered 03/31/23. 2.Tracheostomy Type: [Name redacted] Size:8UN85H Routine trach care daily and as needed, change fastener weekly, and please order 3 appropriately sized tracheostomies to keep at the bedside, I will change the trach at my next visit. Please also order a box of appropriately sized inner cannulas to keep at the bedside. [NAME] one time a day for trach care. Ordered 04/06/23. The LPN/ UM stated that the above orders should have been clarified because it had too many orders in one PO, and they were not transcribed onto the TAR. The LPN/UM further stated, the nurse should have called the doctor and clarified the order when the nurse acknowledged the PO in the electronic MAR or during the 24-hour chart check. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/01/24 at 12:03 PM, the surveyor interviewed the DON who stated that all medication and treatments were to be signed out upon rendering the treatment or medication and there should not be any blanks on the MARs and TARs. The DON, in the presence of the surveyor, reviewed the above oxygen and tracheostomy orders and the DON stated that the PO's should have been clarified either when the nurse acknowledged the order or during the 24-hour chart check. When a nurse acknowledged a PO, they would review the order to make sure it was a complete order and if they had any questions, they would call the doctor to get the order clarified. The DON confirmed that the physician orders were not ordered correctly and were not transcribed onto the MARs and TARs. The DON further stated the above POs should have been clarified because it was important to prevent respiratory distress in a resident with a tracheostomy. A review of the facility's Oxygen Administration policy, undated, indicated to verify that there is a physician order and to review the physician's orders or facility's procedure for oxygen administration. A review of the facility's Medication Orders policy undated, revealed that for Oxygen Orders to specify the rate of flow, route, and rationale (i.e., O2 (Oxygen) 2/3 L/min per nasal cannula prn SOB). A review of the facility's Physicians Orders policy undated, reflected that orders for medications must include a. Name and strength of the drug; b. Quantity and specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration if other than oral; and e. Reason or problem for which given. A review of the facility's Charting/Documenting Policy undated, reflected that the purpose of these guidelines is to ensure complete comprehensive and timely documentation of the residents'/patient 'care, treatment, response to care, signs, symptoms, change in condition as well as the progress of the resident/patient. Under Medication Administration: the date and time medication administered on the Medical Administration Record. Document reason for refusal of medication on the nurses note. Initial of person in appropriate body on Medex. Under treatments: All treatments requiring a physician's order, or nursing intervention must be documented on Treatment Record. The Nurse completing the treatment must initial in the appropriate section on the record. A review the facility's Physician Order Chart check Policy,undated, included: is to ensure that physicians orders are correctly carried over from the (POS) Physician Order Summary to MAR/TAR. The 11pm -7am Nurse will: Review each chart checking for medication orders, lab orders, consultation sheets against the MAR/TAR and Lab book. if the order has been missed, the 11-7 nurse will transcribe the order sign that it was noted on the TAR/MAR/Lab sheet and sign the POS and fax it to the pharmacy. At the bottom of the POS the nurse will write 24-hour chart check and sign it. The nurse will review all newly admitted resident's medication orders and check that they were processed correctly as above and write 24-hour chart check on the admission POS and sign it. 4.The nurse will report any missed orders to the unit manager to educate staff members on the importance of accuracy in health care. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	NJAC 8:39 25.2(b), (c)4, 27.1(a)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 40041 Based on interview and record review, it was determined that the facility failed to ensure that all certified nursing staff hired by the facility had certifications in good standing. This deficient practice occurred to 2 of 10 newly hired CNAs (certified nurse aides), (Employees #3 and #8) that were newly hired. This deficient practice was evidenced by the following: On 10/1/24 at 1:32 PM, the surveyor reviewed the employee files of 10 randomly selected CNAs that was recently hired. The following was revealed: A review of the employee file for Employee #3 with a hire date of 9/19/24, did not contain evidence that her certification was verified prior to employment. A review of the employee file for Employee #8 with a hire date of 7/6/23, did not contain evidence that her certification was verified prior to employment. On 10/1/24 at 2:34 PM, during an interview with the surveyor, the Human Resource Director (HRD) confirmed that Employee #3 and Employee #8's employment files did not contain verification. She continued by stating that the state registry should be checked for verification. After the CNA was verified, the verification was printed out and kept in the employee's employment file. A review of the facility's Residents/Patient Rights - Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property undated policy, included .Screening Procedures A. Screening of all employees are screened prior to employment 2. Facility will be thorough in the investigation of past histories of individuals hired. This will be done through: a. Inquiry of State Nurse Aide Registry. NJAC 8:39-43.15

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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. 37547 Complaint #: NJ169862 Based on observations, interviews, record review, and review of other pertinent documentation, it was determined that the facility failed to: 1) develop and implement a comprehensive policy to maintain a system of accountability for the back up storage of controlled medications (drugs that are tightly controlled by the government because of the risk of abuse and addiction) 2) store insulin pens (a device used to inject insulin to reduce blood sugar levels in persons with diabetes) in a safe and sanitary manner to prevent the spread of infection, and 3) administer a medication used to treat high blood pressure (Labetalol HCL (hydrochloride)) in a timely manner in accordance with the facility policy and professional standards of nursing practice. This deficient practice was identified for 1 of 1 automated medication dispensing systems reviewed in 1 of 2 medication rooms (Third Floor Medication Room), and for 4 of 4 medications carts reviewed for insulin pen storage, and for 1 of 1 closed record (Resident #314) reviewed for medication administration. This deficient practice was evidenced by the following: 1. On 9/30/24 at 8:23 AM, the surveyor met with the Director of Nursing (DON) who agreed to demonstrate the cycle count (system to count the inventory of controlled medications in the automated medication dispensing unit) with a required second nurse, the Licensed Practical Nurse/Infection Preventionist (LPN/IP), during the inspection of the third floor medication room. When the surveyor asked to review the shift to shift sign in book to verify that two nurses performed the count in accordance with the facility policy, the DON stated that we had issues with the log book previously during survey and there was a recommendation to get rid of it. The DON stated that she would print out a log from the automated medication system which kept a record of when the cycle count was performed. The DON failed to print the report of accountability at that time and indicated that she required assistance to perform that function. The DON stated that she did not know how to print a discrepancy report to show the surveyor that there were no discrepancies identified since the last cycle count. At that time, during the cycle count, the DON and the LPN/IP noted that there was a discrepancy for Roxicodone (a controlled medication used to treat moderate to severe pain) 20 mg (milligrams) and stated that 94 tablets were counted, that the count was different and they were resolving it from yesterday. The DON stated that two nursing staff who were identified documented that there were 96 tablets that remained, and pulled two tablets, and miscounted by one and entered 93, when the count should have been 94. The DON stated, I will print the discrepancy for you. The DON stated, That was not the count (correct count). We are resolving a discrepancy from yesterday. The DON stated that when there was a discrepancy nursing should let me know and the automated dispensing system picks it up and sends a notification to me. The DON denied receipt of any notification of a discrepancy and further stated, I have to check my texts. On 9/30/24 at 10:21 AM, the surveyor requested policies regarding the Shift to Shift Narcotic (controlled medications) Count for the automated medication system, and the Process for resolving discrepancies for the automated medication dispensing system. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 11:52 AM, the Regional Director of Nursing (DON) provided the surveyor with a policy titled, Controlled Substances dated 02/24, and stated that the facility did not have a policy that specifically addressed the automated medication dispensing system. The surveyor reviewed the policy and noted that the policy only pertained to the count of controlled drugs on each medication cart at the end of each shift by the nurse coming on duty and the nurse going off duty. A review of the policy revealed that they (nursing) must document and report any discrepancies to the Director of Nursing Services. The policy failed to specify and detail the process for nursing to maintain accountability of controlled medications and discrepancies when identified in the automated dispensing medication system. On 9/30/24 at 12:54 PM, the Director of Nursing (DON) provided the surveyor with a document titled, 3rd floor automated medication dispensing system count [sic] for September 2024. A review of the document revealed that the form was paper based, and was not printed out of the automated medication dispensing system as previously described by the DON. The surveyor reviewed the document which indicated that the count was completed every shift by two nurses who printed their initials only and whether the count was correct by filling in a Y (yes) or N (no). On 9/29/24 on the 3PM to 11 PM shift the Registered Nurse/Supervisor (RN/S) documented that he performed the cycle count with another nurse and indicated that there were no discrepancies noted during the count. On 9/30/24 during the 11 PM to 7 AM shift the DON and LPN/IP documented N, to indicate the count was not correct and in the field allotted for F/U (follow up) Actions Taken documented report error by Sup (Oxy 20) resolved Oxy 20 mg count on 9/30/24) and the entry was initialed by the DON and LPN/IP. During an interview with the surveyor on 9/30/24 at 12:26 PM, the surveyor interviewed the Licensed practical Nurse/Unit Manager (LPN/UM) who stated that she did not know the process for counting the automated medication system, but she guessed that it should have been counted every shift like the medication cart. The LPN/UM stated that she only counted the contents of the automated medication system when we put narcs (narcotics) in, when they were received from the pharmacy and was not involved in the day to day process. During an interview with the surveyor on 9/30/24 at 1:02 PM, the DON was asked where the 3rd floor automated medication dispensing system count was for September 2024 when it was requested by the surveyor during the inspection of the controlled medication inventory? The DON stated that she got rid of the shift to shift narcotic accountability book in 2021, because there was too much discrepancy with the book. The DON stated that we just got the new automated medication dispensing machine two to three months ago. The DON stated that the Office of Resiliency (a state agency) was here and the representative asked me if there was a way to retrieve the information from it. The DON stated that the representative made a recommendation for us to have documentation because I do not know how to retrieve cloud information. The DON stated that we were not documenting shift to shift accountability for the controlled medication dispensing system prior to August, so I have provided you with written documentation now for September of 2024. The surveyor asked why the documentation were not available to view when initially requested and why only the Month of September were provided as she indicated that documentation was also recorded in August of 2024. The DON stated that it was a miscommunication and she agreed to provide it. The DON stated that the RNS texted her and made her aware of the discrepancy that was created in the automated medication dispensing system on 9/20/24 during the 3-11 shift . The surveyor requested to see the text at that time and the DON stated, I do not have the text. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 2:10 PM, the LPN/IP provided the surveyor with a copy of the 3rd floor Automated Medication System Count for August 2024. During a telephone interview with the surveyor on 10/1/24 at 10:00 AM, the Consultant Pharmacist (CP) stated that the facility was supposed to maintain a shift to shift accountability log for the automated medication dispensing system to ensure the counts were accurate and there was no diversion (theft) between shift to shift. The CP further explained that she was not responsible for the oversight of the automated medication dispensing machine, the provider pharmacy was. The surveyor obtained contact information from the facility and attempted to reach the provider pharmacy representative and their designee, who were not available for interview. During a telephone interview with the surveyor on 10/1/24 at 3:01 PM, the RNS stated that he worked at the facility for about a year. He stated that the automated medication dispensing system was was counted by two nurses and was only counted when it was being filled or when a narcotic was removed. The RNS stated, The automated medication dispensing system was not counted on a routine basis. The RNS stated that he worked full-time and that when there was a discrepancy because the count was not correct, the drawer will not open, it will not let you go ahead. He stated, one time I was told there was a discrepancy and the count on the screen was not the count. The RNS stated I called the DON right away when it happened. During an interview with the surveyor on 10/2/24 at 10:02 AM, when the surveyor asked the LPN/IP if the documentation for the automated medication dispensing system was in place prior to the observation on 9/30/24, the LPN/IP stated, I do not want to put my foot in my mouth. The LPN/IP further stated, I have no explanation at all for this. 2. On 9/30/24 at 9:10 AM, during the Medication Storage Task, the surveyor inspected the Three [NAME] Medication Cart in the presence of Licensed Practical Nurse (LPN) #4. In the top left drawer, the surveyor observed three insulin pens that were stored together within a single compartment of the drawer and were not kept in a plastic bag. LPN #4 stated that the insulin pens belonged to Resident #5, Resident #41 and Resident #103. When the surveyor asked what the policy was regarding insulin pen storage, LPN #4 stated that she was unsure and further stated, Is it supposed to be in a bag? During an interview with the surveyor on 9/30/24 at 9:30 AM, the LPN/IP stated that insulin pens were stored in the top drawer of the medication cart with the rest of the insulin pens. The LPN/IP stated that she was used to keeping them in a bag at the previous facility that she worked at. The LPN/IP stated that the Consultant Pharmacist (CP) inspected the medication carts and had not said anything about the insulin pens not being stored in a bag. The LPN/IP stated that there was no policy related to the storage of insulin pens that she was aware of. The LPN/IP stated that she had been in the role of IP since 7/2/24, and got her certification on 7/19/24, and infection control was a broad topic. On 9/30/24 at 9:37 AM, the surveyor inspected the Two [NAME] Medication Cart in the presence of LPN #5. In the top left drawer, the surveyor observed two insulin pens that were stored together. LPN #5 stated that the insulin pens belonged to Resident #38 and Resident #16. LPN #5 stated that the insulin pens were always stored in the drawer. When the surveyor asked if the pharmacy dispensed the insulin pens in a plastic bag LPN #5 stated, We always throw the bag away. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 10:04 AM, the surveyor inspected the Three [NAME] Medication Cart in the presence of LPN #8. In the top left drawer, the surveyor noted three insulin pens were stored together and were not kept in a bag. LPN #8 stated that the insulin pens all belonged to Resident #77. LPN #8 stated that the insulin pens were kept in a bag, but sometimes we replaced it. During an interview with the surveyor on 9/30/24 at 12:26 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that insulin pens usually came in a bag which was labeled with the resident's name on it. The LPN/UM stated that she would leave the insulin pen in the bag and write the date that the pen were opened because it was good for 28 days. The LPN/UM stated there was a potential to pick up the wrong one if it were not in a bag. The LPN/UM further stated that it would also need to be wiped off after use if it were not stored in a bag to prevent the spread of infection. During an interview with the surveyor on 10/1/24 at 9:46 AM, the CP stated that she worked at the facility for four to five years. The CP stated that once insulin pens were opened they needed to be dated and put right back into the baggy for infection control purposes. The CP further stated, It should be in the baggy. When the surveyor asked the CP if she noted the storage of multiple insulin pens belonging to different residents being without a baggy during the medication cart inspections that she performed she stated, I could not say that I have seen that, as the pharmacy sends them in a bag. On 10/1/24 at 10:45 AM, the surveyor inspected the Three North Medication Cart in the presence of LPN #7. In the top left drawer, the surveyor noted that there were three insulin pens stored together in the same compartment. LPN #7 stated that multiple insulin pens were delivered for a single resident and were stored in a bag in the refrigerator. LPN #7 further stated that a single pen was then pulled from the bag and placed into the medication cart without a bag to cover it. LPN #7 stated that the insulin pens belonged to Resident #219 and Resident #26. LPN #7 further stated that Resident #26 was discharged yesterday and then proceeded to remove the resident's insulin pen from the medication cart. During an interview with the surveyor on 10/1/24 at 10:54 AM, the Director of Nursing (DON) stated that after surveyor inquiry, she asked the CP what the purpose was for storing insulin pens in a bag? The DON stated that she was informed that the bag was used for infection control reasons. The DON further stated, Now we are aware of a need to store the insulin pens in the bag. 3. A review Resident #314's closed record revealed an Admission Record (an admission summary) which indicated that the resident was admitted to the facility with diagnosis which included but were not limited to: Essential (Primary) hypertension (abnormally high blood pressure often due to obesity, family history or an unhealthy diet), hypothyroidism (abnormally low activity of the thyroid gland that results in metabolic changes in adults), morbid obesity and anxiety disorder, unspecified. A review of Resident #314's most recent quarterly Minimum Data Set (MDS), an assessment tool, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was fully cognitively intact. A review of Resident #314's Progress Notes (PN) revealed an entry written in the Physician's Progress Notes with an effective date of 07/04/23 at 18:48 (6:48 PM), Late Entry Medical Necessity Visit for Date of Service : 07/04/23. Subjective Interval History & Chief Complaint: .Continue with Labetalol for hypertension. Monitor his/her blood pressure .Continue with current medications as ordered . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Impression: Overall deconditioning. Generalized muscle weakness. Ambulatory dysfunction. Morbidly obese .Recent acute respiratory distress. Asthma exacerbation .Hypertension .Plan .continue Labetalol for hypertension. Monitor his/her blood pressure . A review of Resident #314's Order Summary Report revealed an order dated 06/09/23, for Labetalol HCL (hydrochloride) Oral Tablet 100 MG (milligrams) (Labetalol HCL) Give 1 (one) tablet by mouth every 12 hours for High BP, Hold if heart rate is less than 60 or SBP (systolic blood pressure, top number) less than 100. The surveyor reviewed the resident's blood pressure and pulse readings that were documented in the EHR (electronic health record) from 07/05/24 through 07/25/24 and all recorded entries indicated that the resident's SBP and Pulse met the conditions of the physician's order to administer Labetalol HCL oral tablet 100 MG to the resident. A review of Resident #314's July 2023 Medication Administration Record (MAR) revealed an entry for Labetalol HCL Oral Tablet 100 MG (Labetalol HCL) Give 1 (one) tablet by mouth every 12 hours for High BP Hold if heart rate is less than 60 or SBP less than 100. The entry was scheduled to be administered at 0900 (9:00 AM) and 2100 (9:00 PM). A review of the MAR revealed that the entry appeared to be given as scheduled daily at both 9:00 AM and 9:00 PM throughout the month of July 2023. On 09/30/24, the surveyor requested to view Resident #314's Medication Admin Audit Report (MAAR, a document that detailed the time exact time of medication administration not detailed on the MAR) for Labetalol HCL Oral Tablet 100 MG administration as ordered. Review of the MAAR revealed that the scheduled 9 AM dose of Labetalol HCL Oral Tablet 100 MG was administered late to the resident on the following dates and times: On 07/06/23 at 10:14 AM, on 07/08/23 at 12:11 PM, on 07/11/23 at 10:51 AM, on 07/18/23 at 10:26 AM, on 07/20/23 at 12:46 PM, on 07/21/23 at 12:06 PM, on 07/25/23 at 10:43 AM, on 07/27/23 at 11:42 AM, on 07/28/23 at 10:06 AM, on 07/30/23 at 1:04 PM and on 07/31/23 at 12:36 PM. Further review of Resident #314's MAAR revealed that scheduled 9 PM dose of Labetalol HCL Oral Tablet 100 MG was administered late to the resident on the following dates and times: On 07/03/23 at 10:43 PM, on 07/04/23 the entry was not charted as administered until 07/05/23 at 1:56 AM, on 07/06/23 at 11:19 PM, on 07/08/23 at 10:21 PM, on 07/09/23 at 11:49 PM, on 07/10/23 the entry was not charted as administered until 07/11/23 at 4:27 AM, on 07/12/23 at 11:04 PM, on 07/16/23 the entry was not charted as administered until 07/17/23 at 1:21 AM, on 07/19/23 the entry was not charted as administered until 07/20/23 at 12:01 AM, on 07/22/23 the entry was not charted as administered until 07/23/23 at 12:07 AM, on 07/23/23 the entry was not charted as administered until 07/24/23 at 12:08 AM, on 07/24/23 at 11:44 PM, on 07/27/23 at 10:38 PM, on 07/28/23 at 11:03 PM, and on 07/30/23 at 11:48 PM. A review of Resident #314's Progress Notes failed to contain documented evidence that the resident's physician was notified that the resident received their scheduled dosages of Labetalol beyond the scheduled administration time. There was also no documented rationale within the resident's EHR to explain why the medication was not administered timely as required. During an interview with the surveyor on 10/1/24 at 10:41 AM, Licensed Practical Nurse (LPN) #7 stated that if a medication were not available for administration, she went to the back up medication system or called the physician. LPN #7 stated that she was permitted to administer medications one hour before or one hour after the scheduled administration time per facility policy. LPN #7 stated that she had enough time to administer her medications on time during her shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315205	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Center for Rehab & Sub-Acute Care	Two Cooper Plaza Camden, NJ 08103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the surveyor on 10/1/24 at 11:20 AM, the Director of Nursing (DON) who stated that medications should be given one hour before or an hour after the scheduled administration time. The DON stated that nursing should document if a resident refused their medication. The DON stated that the nurse needed to be educated if the medications were not administered on time because it was not acceptable. During an interview with the surveyor on 10/2/24 at 11:58 AM, the Registered Nurse/Supervisor (RN/S) stated that the facility may have lost the Internet and was not able to sign his medications out on time when he administered medications to Resident #314. The RN/S stated that medications should be given one hour before or one hour after the scheduled time. RN/S further stated, we always give medications on time. During an interview with the surveyor on 10/2/24 at 1:29 PM, the [NAME] President of Clinical Services (VPCS) stated that the facility had a back up electronic medication administration record if the Internet were to go out. The VPCS explained that it was hooked up to a computer with a generator back up. The VPCS stated that if the Internet went out we used a hot spot for computer access and staff were able to use the computer. The VPCS stated that if paper emar were used, it could be scanned into the EHR. The VPCS was not aware of any Internet outages in July of 2023. The DON was present at that time, and did not report any circumstances that could have contributed to delayed medications administration for Resident #314. A review of the facility policy, Controlled Substances (02/24) revealed the following: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. .The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify responsible parties. The Director of Nursing Services shall maintain a list of individuals/personnel who have access to drug storage areas and controlled substance containers. A review of the facility policy, Storage of Medications (02/24) revealed the following: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received . The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. .Drugs shall be stored in an orderly manner in cabinets, drawers, carts. or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. A review of the facility policy, Medication Administration Policy (02/24) revealed the following: The facility shall administer all resident medications according to physician's orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315205	A. Building B. Wing	10/03/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Licensed nursing professionals will administer mediations [sic.] according to times of administration determined by the facility. .Medication administration pass may begin sixty (60) minutes before the scheduled times of administration buy [sic.] may not exceed sixty (60) minutes after the scheduled times of administration. .Medications administered outside the prescribed timeframe requires physician notification and documentation in the medical record in the Interdisciplinary Progress Notes and/or on the MAR, stating reason for change of time and physician response . A review of an undated facility policy, Charting/Documentation Policy revealed the following: .Medication Administration: The date and time medication administered on the Medication Administration Record .Pulse and blood pressure when appropriate . NJAC 8:39-29.2(a), 29.4 (11) (1), 29.4 (d) (3), 29.7 (c), 27.1 (a)