

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER Willow Springs Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1049 Burnt Tavern Road Brick, NJ 08724	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>50919</p> <p>Complaint #: NJ156378, NJ157304, NJ157715, NJ158101, NJ159337, NJ159347, NJ159775, NJ160752</p> <p>Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure the personal privacy of a resident's body during an incontinence care check.</p> <p>This deficient practice was identified for 1 of 1 residents reviewed for privacy (Resident #14) and was evidenced by the following.</p> <p>According to the Admission Record (AR), Resident #14 was admitted to the facility with diagnoses which included but were not limited to, Diabetes (high blood sugar levels), Depression (a mood disorder that causes persistent sadness and loss of interest), and Unspecified Epilepsy (a neurological disorder that causes seizures).</p> <p>1.) On 07/03/2024 at 9:59 A.M., the Surveyor observed Resident #14 in bed with head of bed elevated at 45 degrees. The Surveyor observed that the Licensed Practical Nurse/Unit Manager (LPN/UM) did not pull the privacy curtain during the incontinence care check.</p> <p>During an interview with the Surveyor on 07/03/2024 at 10:24 A.M., the LPN/UM stated that she does not know why she did not pull the privacy curtain.</p> <p>N.J.A.C. 8:39 - 4.1(a) (16)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50919</p> <p>Complaint#: NJ159347</p> <p>Based on observations and interviews, it was determined the facility failed to maintain a clean and homelike environment for 1 of 3 nursing units (Applewood Unit).</p> <p>The deficient practice was evidenced by the following:</p> <p>The surveyor toured the Applewood Unit on 07/03/2024 and observed the following:</p> <p>1.) On 07/03/2024 at 9:05 A.M., upon entering the unit, the Surveyor noted a strong urine odor on the unit. The Surveyor observed the Housekeeper on the unit during the tour.</p> <p>2.) On 07/03/2024 at 1:55 P.M., the Surveyor returned to the unit and as soon as the doors to the unit were opened, the Surveyor noted a strong pungent odor. The Surveyor noted a strong odor of feces while on unit. The Surveyor did not observe any dirty linens on the cart during the tour. Incontinence care was not being provided during that time.</p> <p>The surveyor toured the Applewood Unit on 07/05/2024 and observed the following:</p> <p>1.) On 07/05/2024 at 9:40 A.M., upon entering the unit, the Surveyor noted a strong urine odor on the unit. The Surveyor observed 2 Housekeepers cleaning the unit.</p> <p>2.) On 07/05/2024 at 10:42 A.M., the Surveyor returned to the unit and noted a urine odor.</p> <p>During an interview with the Surveyor on 07/05/2024 at 10:43 A.M., the Licensed Practical Nurse/Unit Manager (LPN/UM) of the Applewood Unit stated the dirty linens were causing the urine odor. The LPN/UM further stated, Laundry picks up the dirty linen every 2 to 3 hours. The LPN/UM confirmed the presence of urine odor on unit. The LPN/UM stated the unit was cleaned in the morning. The LPN/UM further stated, the [NAME] does the floors, and the Housekeeper cleans the rooms twice a shift. The LPN/UM stated, all staff are responsible for controlling odors on the unit.</p> <p>During an interview with the Surveyor on 07/05/2024 at 12:38 P.M., the Housekeeping Director (HD) stated that rooms were cleaned twice a day. The HD further stated, I check the rooms to see if they are cleaned. The HD stated the Certified Nursing Assistants (CNAs) were responsible for changing the linens. The HD stated the odor was brought to his attention by one of the nurses.</p> <p>Review of the undated facility policy titled Work Schedules, Environmental Services revealed under Policy Interpretation and Implementation 3. Cleaning schedules are developed and implemented to assure that each area of our facility is maintained in a safe, clean, and comfortable manner.</p> <p>NJAC 8:39-4.1(a) (11)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45622</p> <p>Complaint #: NJ159337</p> <p>Based on interviews and records review on 07/02/2024, 07/03/2024 and 07/05/2024, it was determined that the facility failed to ensure a resident (Resident #19) was free from a medication error for 1 resident of 3 residents (Resident #19) reviewed for medication administration and follow their policy titled Medication Administration. Resident #19 received medication in error that was not prescribed to be administered to the resident.</p> <p>This deficient practice was evidenced by the following.</p> <p>According to the Admission Record (AR), Resident #19 was admitted to the facility with diagnoses which included but were not limited to Major Depressive Disorder (Mood disorder that causes a persistent feeling of sadness), Constipation (problem passing stool), Unspecified Dementia (impaired ability to remember, think or make decisions), Abnormal Gait and Dysphagia (difficulty swallowing).</p> <p>According to the Quarterly Minimum Data Set (MDS), an assessment tool dated 10/21/2023, Resident #19 had a Brief Interview of Mental Status (BIMS) score of 0/15, which indicated the Resident was severely cognitively impaired.</p> <p>According to the facility's form titled Incident report, dated 11/1/2022 at 2:30 p.m., under type revealed: Medication Incident, location: Applewood Unit.</p> <p>Review of Resident #19's Electronic Medical Record under allergies revealed: No Known Allergies.</p> <p>According to the facility's form titled Individual Statement Form dated 11/1/2022 at 2:30 p.m., location: Applewood Unit revealed the following information. I administered an antibiotic to the wrong patient (Resident #19) during medication pass. I was educated afterwards on the 7 rights of medication administration: right patient, right drug, right dose, right time, right route, right reason, and right documentation.</p> <p>During an interview on 07/05/2024 at 1:55 p.m., the Regional Director of Specialty Program (RDSP) revealed that the process of medication administration included following the 5 rights of medication administration, give the medication and document. She continued to state, it is the right of the resident not to receive the wrong medication and I would expect the nurse to follow the physician's order and regulations about medication pass.</p> <p>During this survey, the Surveyor was unable to reach the nurse who administered the wrong medication to Resident #19.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy with revision date April 2019 titled Administering Medications under Policy Statement revealed: Medications are administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation #9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 26. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services.</p> <p>NJAC 8:39-29.2 (d)</p>		