STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315222	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barnegat Rehabilitation and Nursing Center	859 West Bay Ave Barnegat, NJ 08005

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43936 Based on observation, interview, record review, and review of pertinent documentation it was determined that the facility failed to ensure the resident's environment is free of accident hazards by failing to use bilateral floor mats as ordered. The deficient practice was identified for 1 of 5 residents (Resident # 31) reviewed under Accidents. The deficient practice was evidenced by the following: A review of Resident # 31's comprehensive Minimum Data Set, dated dated dated [DATE] revealed that Resident # 31 had a fall prior to admission. A review of Resident # 31's Order Summary located in the Electronic Medical Record (EMR) revealed an order for, Mats at the bedside while in bed every shift for safety. The order became active on 09/21/2024. A review of Resident # 31's Treatment Administration Record for October of 2024 revealed the order for, Mats at the bedside while in bed every shift for Safety was indicated as administered for each shift up until the time of surveyor review. A review of Resident # 31's Care Plan located in the EMR revealed a focus, I am high risk for falls [related to] gait/balance problems, toe fractures, and multiple falls prior to admission. Actual fall 9/20/2024. The Care Plan also revealed an intervention for, Bilateral Mats next to bed while in bed for safety. The intervention was initiated on 09/21/2024. A review of the EMR under, Diagnoses revealed a diagnosis of but not limited to repeated falls. On 10/24/2024 at 10:48 AM, during an interview with the surveyor, Resident # 31 said he/she had three falls at home. At that time, the surveyor observed a mat on the floor located on the right side of the bed and the other folded against the wall. On 10/25/2024 at 8:32 AM while in Resident # 31's room, the surveyor observed Resident # 31 in bed. At that time, the surveyor also observed one mat on the floor to the resident's left side. On the right side, a mat was folded in half and placed against the wall. It was placed on the floor adjacent to the bed. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 9:35 AM, the surveyor observed Resident # 31 in bed with one of his/her legs off the bed near the floor. At that time, the surveyor observed one mat on the floor adjacent to the bed and the other folded up against the wall. At that time, Resident # 31 told the surveyor he/she had a bad fall at home prior to admission. On 10/30/2024 at 9:33 AM, the surveyor observed Resident # 31 in bed. At that time, one floor mat was folded on its side in the room. On the same date at 1:10 PM during an interview with the Director of Nursing (DON), the surveyor asked if floor mats for the bedside be folded up and against the wall. The DON replied that depending on the situation, the concern is that when you have someone with a bed side table access can be difficult. On 10/31/2024 at 10:12 AM during an interview with the surveyor, the DON explained that since Resident # 31 was becoming more independent, going forward only one fall mat on one side will be used and the bedside table will be on the other side of the bed. A review of the facility provided policy titled, Falls and Fall Risk, Managing revised October 2023, revealed under, Resident-Centered Approaches to Managing Falls and Fall Risk that, 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors(s) of falls for each resident at risk or with a history of falls. S 8:39-27.1 (a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49712 Based on observation, interview, and record review, it was determined that the facility failed to establish a system of records for all controlled drugs in sufficient detail to enable an accurate reconciliation for the dispensing of controlled medications for 2 out of 3 medication carts inspected. This deficient practice was evidenced by the following: On 10/30/2024 at 10:06 AM, in the presence of the Licensed Practical Nurse (LPN)# 1, the surveyor inspected the medication cart on the second floor labeled the high side cart for storage and labeling of medications. During reconciliation of controlled medications, the surveyor observed 8 Xanax (a narcotic medication used to treat anxiety) 5mg (milligram) in the blister pack in the narcotic box, but the Controlled Drug Sheet (CDS) documented 9 were left. LPN #1 stated that he forgot to sign that out this morning, and that he should have signed it out the minute he gave it. On 10/30/2024 at 10:15 AM, in the presence of LPN# 2 the surveyor inspected the medication cart on the first floor labeled low side cart 2 for storage and labeling of medications. During reconciliation of controlled medications, the surveyor observed 38 Oxycontin (a narcotic medication used to treat pain) 60mg in the blister pack but the CDS documented 39 were left. LPN #2 stated that she should have signed the CDS after giving the medication and that she thought she had signed it. During an interview on 10/30/2024 at 01:10 PM with the surveyor, the Director of Nursing said that narcotics should be signed out in the CDS when given to keep track of the medications. Review of the facility's policy titled, Controlled Substances revised June 2023, revealed under Upon Administration that The nurse administering the medication is responsible for recording: 5. Quantity of medication remaining. NJAC 8:39-29.7(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43936 Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility staff failed to use appropriate infection control practices specifically by failing to wear a gown when providing wound care. The deficient practice was identified for 1 of 2 (Resident # 27) residents reviewed for Pressure Ulcer/Injury. The deficient practice was evidenced by the following: A review of Resident # 27's physician's orders located in the Electronic Medical Record (EMR) revealed that he/she was receiving Santyl External Ointment (topical ointment enzyme that breaks down collagen) applied to the left trochanter wound topically every day shift for healing. The order further revealed to cleanse with acetic acid 0.25%, pat dry, apply santyl, calcium alginate, and cover with a [clean dry dressing]. A review of Resident # 27's diagnoses located in the EMR, revealed a diagnosis of but not limited to a pressure ulcer on the left hip. On 10/25/2024 at 12:36 PM, with permission from Resident # 27, the surveyor observed his/her wound care provided by Registered Nurse (RN) # 1. At that time, the surveyor observed an orange sign on the room door that read, Enhanced Barrier Precautions. The sign revealed that, Everyone Must: clean their hands including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for following high-contact resident care activities: Dressing Bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound care: any skin opening requiring a dressing. RN # 1 entered the room without wearing a gown. During the observation of the wound care, RN # 1 did not wear a gown throughout the entire process. At the time the wound care concluded, the surveyor asked RN # 1 whether they should have worn a gown. RN # 1 replied saying they walked right past the sign. He further stated that Resident # 27 was not on isolation but they walked past the sign on the door. The surveyor did not observe a bin outside of the room containing an personal protective equipment such as gowns. On the same date at 1:18 PM during an interview with the surveyor, the Infection Preventionist (IP) replied, He should've. when asked if RN # 1 was supposed to wear a gown when performing wound care on Resident # 27. The IP confirmed that Resident # 27 has been on Enhanced Barrier Precautions since August of 2024. The IP clarified that Resident # 27 also has a central line (catheter placed in a large vein, often in the neck, chest, or groin, to administer medication, fluids, or collect blood). The surveyor asked when does a staff member have to wear a gown in that room. The IP replied, If they are accessing any of those items, wounds . A review of the facility provided policy titled, Enhanced Barrier Precautions dated April 2024 revealed, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. and, 3. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S 8:39-19.4 (a)