STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315243	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millville Center	54 Sharp Street Millville, NJ 08332

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 18750 NJ00170135 Based on interview, record review, and review of the facility's policy, the facility failed to report an allegation of abuse to the State Survey Agency (SSA) immediately, but not later than two hours for one of 12 sampled residents reviewed for abuse/neglect and injuries of unknown origin (Resident (R)10). This deficient practice had the potential to allow residents of suspected abuse to go unreported to the SSA. Findings include: Review of facility's policy titled, Abuse Prohibition, revised 10/24/22, revealed . Centers prohibit abuse, mistreatment, neglect, misappropriation of resident/patient (hereinafter patient) property, and exploitation for all patients. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. Centers also strive to comply with the Elder Justice Act (EJA). Under the EJA, employees are designated as mandated reporters and are obligated to immediately report any reasonable suspicion of a crime against a patient. Reporting a reasonable suspicion of a crime only to an immediate supervisor does not meet the obligation to report. Retaliation in any form against an employee who reports a reasonable suspicion is strictly prohibited.7. Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following. 7.2 Report allegations involving abuse (physical, verbal- sexual mental) not later than 2 hours after the allegation is made. Review pf the facility's Internal Investigation report for an employee to resident verbal abuse involving R10 dated 01/23/24 revealed an allegation, Certified Nursing Assistant (CNA) 4 called R10 a liar. The investigation indicated the incident was not called in until 02/16/24. During an interview on 05/30/24 at 9:41 AM, R10 was asked how the staff treats her. R10 recalled, There was a time this woman was very rude to me, called me names, but I do not know her name. I told my daughter about it. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/24 at 11:41 AM, the Social Services (SS) staff was asked if she could recall the alleged abuse between CNA4 and R10. The SS stated, I remember [R10's Name] sitting at the doorway to his/her room, and he/she motioned for me to come over. The resident was highly upset because he/she and the aide had gotten into an argument the evening before about sandwiches and the resident stated the CNA called him/her a liar. I made the ADON (Assistant Direction of nursing) aware. During an interview on 05/30/24 at 12:30 PM, the ADON was asked about the investigation. The ADON stated, The Director of Nursing (DON) was on vacation at the time. I investigated the incident. The resident was upset and stated the CNA had been rude to her. I investigated it like a grievance. It was later the DON reported it to state as abuse. I think Corporate told her to report it. During an interview on 05/31/24 at 11:09 AM, the DON was asked why the allegation of abuse was called in a month after the incident occurred. The DON stated, It was after I spoke with the daughter that it was called in. It was reviewed as a grievance until then. The resident started to cry, and I figured it better be called in.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728 NJ00156215 Based on record review, and interview, and facility policy review, the facility failed to ensure a Licensed Practical Nurse (LPN) and a Certified Nursing Assistant (CNA) provided services according to accepted standards of clinical practice with medication administration for one resident (Resident (R) 2) out of 25 sampled residents. Findings include: Review of Review of R2's Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnosis of diabetes, cirrhosis of the liver, anemia, and dependence on dialysis. Review of R2's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 03/12/24, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident was moderately cognitively impaired. Review of the facility's investigation concluded on 07/13/22, revealed on 07/11/22, R2 was scheduled for dialysis and morning medications were due. The resident had previously stated that he did not want LPN1 as his nurse. LPN1 was the nurse on duty and had previously been educated to call for the nursing supervisor to administer the resident's medication per resident request. LPN1 stated that she called the unit where the supervisor was working but she did not answer. She also tried to call another nurse, but she did not answer the unit phone. Transportation to take the resident to dialysis was on the way to the facility so she asked CNA2 if she would check the resident's blood glucose, administer his insulin, and one oral medication. The nurse stated she stood outside the resident's door and observed the CNA administer the medications and she felt comfortable since the CNA was also a diabetic and administered his own finger sticks and insulin. Review of the July 2022 Medication Administration Record (MAR) revealed the medication was signed off by LPN1, even though she did not administer the medications. Review of the written statements by LPN1 and CNA2 confirmed the events that were included in the facility's investigation of the incident. Both staff were terminated from employment by the facility. Interview with LPN17 on 05/29/24 revealed that she would never ask a non-licensed employee to administer any medications to a resident especially insulin. She said she would report any concerns to her supervisor if she was aware of this happening. Interview with LPN27 on 05/29/24 at 4:40 PM revealed that if she was unable to administer any medications to a resident for any reason, she would contact her supervisor immediately or ask her unit manager. She would never ask a CNA to administer any medications to a resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA28 on 05/31/24 at 11:15AM revealed she would never give a resident any medications. The CNA stated administering medications was not in her training. She would report the nurse to her supervisor if she was asked to. Interview with CNA30 on 05/31/24 at 11:45AM revealed she would not give any medications to any resident. If she was asked to, she would immediately report it to her unit manager or supervisor. During an interview with the Director of Nursing (DON) on 05/30/24 at 10:00 AM revealed after the investigation, she terminated both employees from the facility, initiated an action plan for delegation of duties for administration of medication, scope of practice for medications, interviewed other residents to make sure only nurses were giving them medication, and followed up weekly. She also stated the resident that was involved in the incident did not have any outcome and remained in the facility. Review is the facility's policy titled, General Dose Preparation and Medication Administration revised on 04/30/24 revealed, This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Facility staff should also refer to facility policy regarding medication administration and should comply with applicable law and the State Operations Manual (SOM) when administering medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728 NJ00171304 Based on observation, interview, record review, and facility policy review, the facility failed to ensure basic infection control practices were followed to prevent cross contamination for two residents of three residents reviewed for wound care (Resident (R) 2 and R24) out of a sample of 25 residents. The facility failed to ensure Enhanced Barrier Precautions were followed by wearing required PPE (Personal Protection Equipment) and wound supplies were placed on a protective barrier when performing wound care. These failures had the potential to cause the spread of infections. Findings include: 1. Review of R2's Admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnosis of diabetes, cirrhosis of the liver, anemia, and dependence on dialysis. Review of R2's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 03/12/24, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident was moderately cognitively impaired. The resident was identified as having a diabetic ulcer on his left foot and was at risk for developing pressure sores. During an observation of wound care for R2 on 05/30/24 at 2:20 PM, Registered Nurse (RN) 18 entered the resident's room and placed a box of disposable gloves, a box containing 4x4 gauze sponges, a bottle of Betadine solution, and two individual packets of Betadine swabs on top of the resident's bed. The nurse disinfected the resident's overbed table, placed a protective barrier to cover the table, removed the swabs from the box, and placed them on top of the barrier. The nurse did not put on a disposable gown prior to starting wound care. Using gloves removed from the box that was also on top of the resident's bed, the nurse cleaned the wound on the left lateral foot with saline and used the two Betadine swabs to paint the surface of the wound which was covered with eschar (a layer of hard, thick, blackened tissue). A 4x4 gauze pad and gauze wrap from the box on the bed were used to cover the resident's wound. After the wound care was completed, the nurse placed the box of supplies and box of gloves on top of her medication cart in the hallway. A sign announcing the resident was on Enhanced Barrier Precautions was not observed on the resident's door prior to and after the observation of wound care. During an interview with RN18 immediately after the observation, she stated that she did not know why she left the items on the resident's bed and only placed the Betadine swabs on the clean barrier. RN18 confirmed she should have cleaned and prepared the barrier before placing any of the supplies for wound care in the room and that she did not think to put on a gown prior to wound care. The RN also confirmed that a sign indicating Enhanced Barrier Precautions was not on the resident's door. She also stated that she should not have placed the box of supplies from the resident's room on her medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R26's Admission Record located in the resident's EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with Stage IV pressure sore, congestive heart failure, hypertension, muscle contractures, dysphagia, heart disease, and Alzheimer's Disease. Review of R26's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an ARD of 04/21/24, revealed the resident was never understood therefore a BIMS assessment was not conducted. The resident was assessed with severely impaired cognitive status. R26 was also assessed as being at risk for developing pressure sores with the presence of a Stage IV pressure sore. During an observation on 05/30/24 at 2:00 PM, RN18 was preparing to conduct wound care on R26's Stage IV pressure sore on the resident's sacral area. She had the treatment supplies on a protective barrier on top of the overbed table. RN18 was not wearing a protective gown as she performed the treatment, only gloves. The wound was cleaned with a normal saline wash and a small square of calcium alginate placed on top of the wound bed and covered with a foam dressing. The nurse changed her gloves appropriately but failed to put on a gown at the beginning of the treatment. The door to the resident's room did not have a sign posted for Enhanced Barrier Precautions during the wound treatment. During an interview with RN18 immediately after the observation of wound care, she confirmed that she should have worn a protective gown when performing the treatment since the pressure sore is a chronic wound. She thought she did not have to since there was not a sign on the door at that time and the cart that was outside of the door had been moved to the room next door. In an interview with RN18 on 05/31/24 at 10:00 AM, she stated that she received training on Enhanced Precautions and basic infection control practices for wound care through her agency and working in medical facilities. During an interview with the Director of Nursing (DON) on 05/30/24 at 2:30 PM, the DON stated the facility had conducted an in-service for all nursing staff on Enhanced Barrier Precautions previously. RN18 was not here at the time. They expect all agency nurses to be trained on all infection control procedures. She confirmed that the nurse should have worn a gown during wound care and the supplies should not have been placed on the bed. The DON stated that according to staff, a sign had previously been on R26's door but for some reason was found in a drawer in her room. Review of the facility policy entitled, Enhanced Barrier Precautions revised on 01/08/24 revealed, In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact Precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms .Procedure: Enhanced Barrier Precautions, 1. Post the appropriate Enhanced Barrier Precautions sign on the patient's room door .PPE used for wound care.