STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315249	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Care Center	499 Pine Brook Road Lincoln Park, NJ 07035

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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 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. 45449 Based on observation, interview, and record review, it was determined that the facility failed to ensure an antipsychotic medication was administered in accordance with professional standards of clinical practice to Resident #112 who had episodes of auditory hallucinations. This deficient practice was observed for one (1) of four (4) nurses who administered to one (1) of six (6) residents during the medication administration observation and 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 registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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 casefinding; 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 8/20/24 at 9:29 AM, during the medication pass observation, the Registered Nurse (RN) reviewed with the surveyor the four (4) medications to be administered to Resident #112 which included Risperidone Solution 1 mg/ml (Risperdal; milligram/milliliter), give 4 ml orally in the morning for schizophrenia, with a start date of 3/26/24. The RN stated he had to add the Risperidone Solution into the cup of water because the resident did not like the taste, and the resident preferred the medication to be taken this way. On 8/20/24 at 9:45 AM, the RN and the surveyor entered the resident's room. The RN verified the resident's name and gave the resident their medication pills, followed with the Risperidone Solution that was diluted in the water. Resident #112 drank the cup that contained the diluted Risperdal and gave the cup back to the RN. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 9:46 AM, while the RN and the surveyor were walking back to the cart, the RN spilled liquid from the cup that contained the diluted Risperidone solution on his hand and threw the cup into the trash bin attached to his cart. The surveyor observed the cup in the trash bin that contained more liquid. On 8/20/24 at 9:49 AM, the surveyor observed the RN sign the electronic Medication Administration Record (eMAR) that he had administered all four medications to Resident #112. At that time, the surveyor, and the RN both looked at the cup in the trash bin and the RN confirmed that he saw the remaining amount of liquid in the cup, and he had not administered the full dose. On 8/20/24 at 10:04 AM, in the presence of the Licensed Practical Nurse, and the surveyor, the RN stated that he should have given the remainder of the diluted Risperdal Solution to the resident. The RN stated he did not think the resident received the entire 4 mg dose as ordered by the physician. At that time, the RN stated in the future he would ensure the resident would receive the full dose. The RN stated he would contact physician, psychiatrists and inform his supervisors. The surveyor reviewed the hybrid medical record for Resident #112. According to the Admission Record, Resident #112 was admitted to the facility with diagnoses which included paranoid schizophrenia, anxiety disorder. A review of a Quarterly Minimum Data Set, an assessment tool, dated 5/31/24, revealed that the resident had a Brief Interview for Mental Status score of 10 out of 15 which indicated that the resident had mild cognitive impairment. A review of the resident's Order Summary Report as of 8/21/24, included an order, dated 3/12/24, for Risperidone 1 mg/1 ml, give 4 ml orally in the morning for schizophrenia. A review of Resident #112's Psychoactive Monitoring Form/Monthly Summary for August 2024 reflected monitoring of resident's behavior, non-drug interventions for the documented behaviors, and the behaviors exhibited and monitored by the nursing staff. The behaviors exhibited were: -two episodes of auditory hallucinations on 8/4/24. -one episode of auditory hallucination on 8/6/24. -one episode of the resident who became verbally upset when asked if it was time to smoke. No confrontation on 8/11/24. A review of the RN's Medication Pass Observation competencies reflected the following: -on 12/1/23, the RN had 0% errors -on 4/18/23, the RN had 9.09% errors -on 5/15/24, the RN had 0% errors (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 1:53 PM, in the presence of the survey team, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concern regarding the medication pass wherein Resident #112 did not receive the full dose of the Risperidone 4 mg that was diluted in water. At that time, the DON stated that the RN was in-service (educated) to ensure the residents received the correct dose. On 8/20/24 at 9:00 AM, the surveyor received a copy of the in-service provided to the RN. A review of the policy provided Administering Medication dated 11/5/23, reflected under Policy Statement that medications shall be administered in a safe and timely manner, and as prescribed. NJAC 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. 45449 Based on observation, interview, and record review, it was determined that the facility failed to consistently provide pharmaceutical services in accordance with professional standards to ensure a.) a refrigerator that contained prescription medications was lockable, b.) disposition (destruction) and reconciliation of controlled dangerous substance (narcotic; medications, that due to their high potential for abuse, are tracked with detail) was removed from active inventory when Unsampled Resident # 399 was discharged from the facility, c.) against borrowing medications from other residents to administer to a newly admitted resident (Unsampled Resident #1073), d.) a discontinued medication for Unsampled Resident #359 was removed from active inventory, and e.) a biological supply that required dating was dated. These deficient practices were identified for one (1) of five (5) medication storage rooms and three (3) of 13 medication carts inspected during the medication storage observation. a.) On 8/20/23 at 10:31 AM, the surveyor observed the medication room door located on 3-West was half opened. At that time, the Licensed Practical Nurse (LPN #1) was in the room. On 8/20/24 at 10:35 AM, during the inspection of the medication room refrigerator in the presence of LPN #1, the surveyor observed the refrigerator had a metal string, that was bolted on the side, and the front of the refrigerator door. The metal string was easily unhooked from the front, and not locked. The refrigerator contained prescription medications such as insulin (injectable medication to reduce blood sugar) and an empty storage box for refrigerated narcotic medication. At that time, LPN #1 stated that the refrigerator was unlocked from the beginning of her shift that morning and did not know if there was a lock for the medication refrigerator. LPN #1 used the telephone to call her supervisor. On 8/20/24 AM at 10:58 AM, LPN #2 walked into the medication room and stated that there was a lock for the medication room refrigerator located on the bolted side of the refrigerator. LPN #2 tried several keys in her possession to demonstrate that the lock was functional. At that time, both nurses tried multiple keys in their possession and could not show the lock for the medication room refrigerator was lockable. On 8/20/24 at 11:01 AM, the Assistant Director of Nursing (ADON) entered the medication room in 3-West. In the presence of LPN #1, LPN #2, and the surveyor the ADON for the 3rd floor tried LPN#1's, LPN#2's and her own set of keys to demonstrate that the prescription refrigerator door was lockable. At that time, the ADON confirmed she did not have the key to lock the refrigerator door, had not received a report from any nurses concerning the lock and was unsure how long the medication room refrigerator door was not lockable. On 8.21/24 at 1:53 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the unlockable refrigerator. At that time, the DON stated that the lock was changed, the staff did not have any prior problems with the lock and was not sure what went wrong. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b.) On 8/20/24 at 10:42 AM, in the presence of LPN #1, the surveyor began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart B (narcotic box) located on 3-West. The medication cart B parked inside the medication room. A review of the facility's Record of Narcotic Use Drug Count and Syringe Count (a shift-to-shift count/sign in sheet, used to account for the narcotics and syringes within the medication cart) for August 2024, reflected that the counts were conducted on three shifts (7:00 AM, 3:00 PM and 11:00 PM), daily from 8/1/24 at 7:00 AM, to at 8/20/24 at 7:00 AM. At that time, the surveyor and LPN #1 observed Resident #399's Lorazepam 1 mg (Ativan; milligram) bingo card (a multidose card containing individually packaged medications) contained 22 tablets. At that time, the surveyor compared the count of the bingo card against the Individual Patient Controlled Substance Administration Record (declining inventory log) for Resident #399's Lorazepam 1 mg tablet which reflected a balance of 23 tablets and was last signed by the administering nurse on 8/13/24 at 9:46 PM. At that time, the surveyor questioned the one (1) tablet discrepancy of the count. LPN #1 stated that she usually signed the declining inventory log but had forgotten that day. LPN #1 stated she removed the Lorazepam 1 mg for administration to Resident #399 that morning, and at the same time was informed that Resident #1073 was seizing at center court. LPN #1 stated she administered the Lorazepam 1 mg to Resident #399 before running to center court, and that was the reason she had forgotten to sign the declining inventory log. At that time, the LPN #1 stated she should have signed the declining sheet upon removal of the Lorazepam 1 mg from the narcotic box. The surveyor reviewed the hybrid medical record for Resident #399. According to the Admission Record, Resident #399 was admitted to the facility with diagnoses that included suicidal ideations, schizoaffective disorder, major depressive disorder, and generalized anxiety. A review of Resident #399's electronic Medical Record reflected the resident was transferred out of the facility on 8/14/24. A review of the resident electronic Medication Administration Record (eMR) reflected the last administration was on 8/13/24. A review of the paper-based chart contained the Universal Transfer Form that indicated Resident #399 was transferred out of the facility on 8/14/24 at 2:19 PM for suicidal ideations. On 8/20/24 at 10:42 AM, the surveyor and LPN #1 reviewed Resident #399's eMR together which revealed Resident #399 was transferred out of the facility on 8/14/24 and had not returned to the facility at that time. The LPN confirmed the Resident #399 was discharged . The missing one tablet of the Lorazepam 1 mg for Resident #399 could not have been administered to Resident #399 since the resident was not in the facility that morning. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 10:46 AM, LPN #1 stated she was part of the error with the shift-to-shift count for the missing narcotic. The LPN stated that she and the 11-7 AM nurse miscounted the narcotics that morning and was unsure when the one tablet of Resident #399's Lorazepam went missing. At that time, the LPN #1 stated the Resident #399's bingo card should have been removed from the cart, should have been sent back to the pharmacy, or should have been disposed by two (2) nurses. On 8/20/23 at 11:03 AM, in the presence of LPN #1 and the surveyor, the ADON confirmed that Resident #399's Lorazepam should have been pulled when they learned the resident was admitted to the hospital on 8/14/24 or 8/15/24. The ADON also stated that this was important to avoid medication errors, misplacement, theft, and proper count of pills should have been returned [when applicable, for credit towards the resident's account]. At that time, the ADON stated she would investigate and inform the Director of Nursing. On 8/20/24 at 1:14 PM, during a meeting with the DON, the surveyor discussed the concern regarding the missing one tablet of Lorazepam 1 mg for Resident #399. At that time, the DON stated that all discharged medications should have been removed once the resident was admitted to the other facility. The DON stated that she would investigate Resident #399's missing narcotic. c.) A review of the provided facility policy dated/revised on 6/12/24. included the following under Policy Interpretation and Implementation. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsibility parties and shall give the Administrator a written report of such findings. The surveyor reviewed the hybrid medical record for Resident #1073. According to the Admission Record, Resident #359 was admitted to the facility with diagnosis that included generalized idiopathic epilepsy syndromes, not intractable, with status epilepticus, and other seizures. A review of the New Jersey Universal Transfer Form reflected Resident #1073 was admitted the day before the unit inspection at 8:00 PM and was transferred out of the facility on that morning at 8:25 AM. A review of the Order Summary Report for Resident #1073 included the following: -Carbamazepine 100 mg chewable, give 2 tablet(s) by mouth three times a day for seizure disorder, ordered on 8/19/24, with a start date of 8/20/24. -Lacosamide 50 mg tablet, give 2 tablet(s) by mouth two times a day for seizure disorder, ordered on 8/19/24, with a start date of 8/20/24. -Lamotrigine 200 mg, give 1 tablet by mouth two times a day for seizure disorder, ordered on 8/19/24, with a start date of 8/20/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Levetiracetam [Keppra] 750 mg tablet, give 2 tablet(s) by mouth every 12 hours for seizure disorder, ordered on 8/19/24 with a start date of 8/20/24. A review of the electronic Medication Administration Record (eMAR) for August 2024 did not reflect an order and an administration of Lorazepam 1 mg. A review Resident #1073's paper-based chart, under progress note, reflected a documentation on 8/20/24 [without time or department], revealed a stat order for Keppra 750 mg and Ativan 1 mg ordered and given. On 8/21/24 at 9:20 AM, during a meeting with the surveyors, the DON stated that she had investigated the missing narcotic after surveyor inquiry, removed the nurse from the cart, counted the narcotics, reviewed the cameras, informed the LNHA, the Medical Director and the Consultant Pharmacist, and filed a reportable with the state and the police department. The DON explained that Resident #1073 had a seizure at approximate 7:30 AM. The physician was notified and placed a stat (immediate) order of Lorazepam 1 mg and Keppra 750 mg. Resident #1073 was admitted the night before and their medications had not yet arrived for the 9:00 AM administration. At that time, the DON stated that LPN #1 borrowed the Lorazepam from Resident #399 and the Keppra from Resident #217. At that time, the DON showed a paper-based Medication Administration for Resident #1073 that revealed, one (1) time administration of the Ativan 1 mg and Keppra 750 mg on 8/20/24 at 7:35 AM. At that time, the DON confirmed the nurse should have gone to the back-up box to get the emergency order of Ativan and Keppra for Resident #1073. At that time, the DON also stated that LPN #1 tried to deny the act of borrowing while the camera showed that she had. At that time, the DON stated that she would contact the pharmacy to ensure Resident #359 received a credit for the misappropriated medication (Keppra). The surveyor reviewed the hybrid medical record for Resident #217 According to the Admission Record, Resident #359 was admitted to the facility with diagnosis that included convulsions. A review of the eMAR for August 2024, reflected an order for Levetiracetam (Keppra) 750 mg, give 1 tablet orally every 12 hours for seizure, started on 4/4/24. The eMAR also reflected that Resident #359 received their scheduled doses. No further information was provided. d.) On 8/20/24 at 11:57 AM, in the presence of the Registered Nurse (RN #1), the surveyor began the medication cart B inspection located on 2-East. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 12:06 PM, the surveyor observed an amber vial that contained Erythromycin Ophthalmic Ointment (antibiotic) for Resident #359. At that time, the surveyor and RN #1 reviewed the electronic Medication Administration Record (eMAR) together which revealed a physician's order for Erythromycin Ophthalmic Ointment, instill 1 application in both eyes two times a day for eye infection until 8/5/24. The eMAR did not reflect the exact measurement (in inches or centimeter) to indicate the dose for each administration. At that time, RN #1 stated that the Resident was sent out of the facility and was admitted to another facility. RN #1 stated the antibiotic ointment should have been removed. RN #1 also stated that Resident #359 was back in the facility but had no current orders for Erythromycin Ophthalmic Ointment. The surveyor reviewed the hybrid Medical Record for Resident #359. According to the Admission Record, Resident #359 was admitted to the facility with diagnosis that included type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy (a diabetic eye disease that can lead to vision loss). A review of the Order Summary Report for August 2024 did not include a current order for Erythromycin Ophthalmic Ointment. On 8/21/24 at 1:53 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the Resident#359's antibiotic ointment, discontinued on 8/5/24, that was intermingled with the active inventory. No further information was provided. e.) On 8/20/24 at 12:30 PM, in the presence of LPN #3, the surveyor began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart B (narcotic box) located on 2-West. At that time, in the back of the narcotic box buried underneath vials of Haldol injectable, the surveyor and LPN #3 observed an opened, undated blood glucose (bg) test strips bottle (used with a glucometer to provide immediate reading of blood sugar, or glucose level). The package insert indicated use within 90 days after first opening. At that time, LPN #3 confirmed the bg test strips should have been dated. LPN #3 stated she would discard the bg test strips since she was unsure when it was opened. A review of the Manufacturer Specification for Assure Platinum included the following under FAQs. What is the operating range for the Assure Platinum Test Strips and how should I store them? Operating range: 39 F-86 F (4 C - 30 C). Use within 90 days of first opening. Do not freeze or refrigerate. Do not use beyond expiration date. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8.21/24 at 1:53 PM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the undated bg test strips that was stored in the narcotic box. No further information was provided. A review of the provided facility policy dated/revised on 6/12/24, included the following under Policy Interpretation and Implementation: 6. The Nurse will maintain the keys to controlled substance for their medication cart. The Director of Nursing Services will maintain a set of back-up keys for all drug storage areas including keys to controlled substance containers. 8. Nursing staff count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing. A review of the provided facility policy, Administering Medications, dated/revised on 11/5/23, included the following under Policy Interpretation and Implementation: 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. A review of the provided facility policy, Charting and Documentation dated/reviewed on 3/7/24, under policy statement reflected: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. A review of the provided facility policy, Storage of Medications dated/revised on 6/15/24, included the following under Policy Interpretation and Implementation: 3 .there is a secured medication locked cabinet to ensure the medication cannot be accessed by other residents 5. The facility shall not use discontinued, outdated, deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. NJAC 8:39-29.2 (d), 29.4(g)(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 Based on observation, interviews, and review of pertinent facility documents, it was determined the facility failed to a.) follow appropriate infection control practices and perform appropriate hand hygiene as indicated during meal service observation in 2 of 12 units (first floor JDT and 2 East) for 2 of 4 staff observed during meal service and, b.) follow appropriate infection control practices and perform hand hygiene as indicated for 1 of 1 Resident (Resident #139) observed during tracheostomy care. This deficient practice was evidenced by the following: A review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. On 8/19/24 at 12:39 PM, the surveyor observed the lunch meal service in the JDT first-floor unit. The surveyor interviewed a Certified Nursing Assistant (CNA #1) who stated that all residents on the unit were served the lunch trays in their rooms. The surveyor observed the CNA #1 approached the food, removed a tray and entered room [ROOM NUMBER]. The CNA #1 placed the food tray on the bed side table (BST) of the resident; removed the plate cover, removed the plastic covering from the food items and silverware on the tray, then opened the hand wipe and cleaned the resident's hands. The CNA #1 moved the BST closer to the resident. The resident requested an alternative food option, so the CNA went directly to the nurse's station and picked up the phone with no observed hand hygiene. The CNA #1 returned to the food cart, removed a tray and entered resident room [ROOM NUMBER]. The CNA #1 placed the food tray on the BST, opened the hand wipe and handed it to the resident. The CNA #1 exited room [ROOM NUMBER], went to a cabinet in the nurse's station, removed a cup and a can of soda, went to the ice cooler removed the lid and filled the cup with ice. The CNA #1 entered room [ROOM NUMBER] with no observed hand hygiene. On 8/19/24 at 12:50 PM, the CNA #1 told the surveyor that all the trays had been passed. The surveyor asked the CNA #1 if it was the facility's policy to perform hand hygiene between residents when assisting with meals. The CNA acknowledged that she should have sanitized her hands between residents. On 8/21/24 at 8:24 AM, the surveyor observed meal service on the 2 East unit. The surveyor observed signage outside room E202 which indicated the resident in room E202 was on Enhanced Barrier Precautions (EBP) which included: everyone must clean their hands, including before entering and when leaving the room; wear gloves and a gown for the following High-Contact Resident Care Activities which included . dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube (gastrostomy tube), tracheostomy; wound care including any skin opening requiring a dressing. (continued on next page)

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Lincoln Park Care Center	499 Pine Brook Road Lincoln Park, NJ 07035

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at that same time, the surveyor observed the CNA #2 approached the food truck, removed a tray and entered room E202. The CNA #2 placed the tray on the BST of the resident in the window bed. The CNA #2 removed the plate cover, removed the plastic covering from the food items and silverware on the tray. The CNA #2 moved the BST closer to the resident. The CNA #2 exited the room without any observed hand hygiene. The CNA #2 approached the coffee cart, brought a cup of coffee into resident room E215. The CNA #2 exited the room with no observed hand hygiene. The CNA #2 returned to the food cart, removed a tray and entered room E217. The CNA #2 placed the tray on the BST and exited the room with no observed hand hygiene. The CNA #2 returned to the food cart, removed a tray and entered room E216. The CNA #2 placed the tray on the BST of the resident in the door bed. The CNA exited the room with no observed hand hygiene. The surveyor observed signage outside room E214 which indicated the resident was on EBP. The surveyor observed the CNA #2 returned to the food cart, removed a tray and entered room E214 and placed the tray on the BST of the resident in the middle bed. The surveyor observed the CNA #2 performed hand hygiene. The CNA #2 turned on the faucet, applied soap to her hands and immediately placed hands under the stream of water without first lathering or applying friction. On that same date at the same time, the surveyor discussed the breaks in infection control with the CNA #2 who acknowledged she should have performed hand hygiene between residents and when she entered and exited a resident's room who was on EBP. The CNA #2 further stated that she should have washed her hands with soap lathering for 20 to 30 seconds outside the stream of water but acknowledge she did not wash correctly because she forgot. 2. On 8/20/24 at 9:28 the surveyor observed the Licensed Practical Nurse (LPN) on 2East unit perform hand hygiene. The LPN turned on the faucet, applied soap and immediately placed her hands under the stream of water without first lathering outside of the water. The LPN turned off the faucet with her bare hands, then dried her hands with a papertowel. On 8/21/24 at 8:36 AM, the surveyor observed signage outside room [ROOM NUMBER] East which indicated Resident #139 was on EBP. The surveyor observed the LPN provide Tracheostomy care to Resident #139. The LPN turned on the faucet, applied soap to her hands, and immediately placed her hands under the stream of running water without lathering or applying friction outside of the stream of water. The LPN dried her hands and used the same paper towel to turn off the faucet. The LPN provided tracheostomy care per the physician's order. During the treatment the surveyor observed the LPN performed hand hygiene at three different times. The LPN applied soap to her hands and immediately placed them under the stream of water without lathering, dried her hands and used the same paper towel to turn off the faucet. On 8/21/24 at that same time the surveyor discussed the above observations and concerns with the LPN. The LPN acknowledged that she should have performed hand hygiene by lathering her hands outside the stream of running water for at least 20 seconds and should have used a clean paper towel to turn off the faucet. The LPN stated that she didn't wash her hands properly because she was nervous. A review of the Hand Hygiene policy and procedure, dated as Revised 9/10/23 revealed .the facility considers hand hygiene the primary means to prevent the spread of infections .Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions . Before and after entering isolation precaution settings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before and after eating or handling food (hand washing with soap and water) Before and after assisting a resident with meals Procedure: Vigorously lather hands with soap and rub them together, creating friction to all surfaces for at least 20 seconds .rinse hands thoroughly .dry hands with paper towels and then turn off faucets with a clean, dry paper towel. Using Alcohol-Based Hand Rubs (ABHR) .apply product to palm of hand and rub hands together, cover all surfaces of hands and fingers until hands are dry. The facility's Enhanced Barrier Precaution Policy dated as revised 3/26/24 revealed .the EBP program is a tool to help control the spread of colonized Multidrug-resistant organisms (MDROs) infections. The facility will use the EBP on all nursing home residents with wounds and indwelling medical devices. These residents are at increased risk for acquisition of and colonization with MDROs .staff shall be adequately trained in the various aspects of EBP to ensure appropriate decision-making in various clinical situations . On 8/21/24 at 11:33 AM, the surveyor interviewed the Registered Nurse/ Infection Preventionist (IPN) who stated that the staff should perform hand hygiene between residents using ABHR or washing their hands following the proper procedure .turn on the faucet, wet hands, apply soap and lather outside the stream of water for 20-30 seconds, rinse hands, dry hands and use a new paper towel to turn off the faucet. The IPN further stated that staff and visitors should sanitize their hands before entering and when exiting the room of a resident who is on EPB. On 8/21/24 at 1:51 PM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator and Director of Nursing who acknowledged that hand hygiene should be performed according to CDC regulations including before entering and exiting a resident's room who is on EBP. No further information was provided. NJAC 8:39 - 19.4(a); (n)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, and record review, it was determined that the facility failed to ensure Resident #114 was offered pneumococcal vaccination according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations. This deficient practice was identified for one (1) of five (5) residents reviewed for immunization status. The deficient practice was evidenced by the following: Reference: A review of the CDC's Advisory Committee on Immunization Practices (ACIP) for Pneumococcal Vaccine Recommendations dated/last reviewed on 2/13/23, included the following. The CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown . A review of the facility's policy for Pneumococcal Vaccine dated/reviewed 9/10/23, included the following: Policy Statement: All residents will be offered Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g. pneumonia). Under Policy Interpretation and Implementation subsection 7 reflected that Administration of the pneumococcal vaccination or revaccination will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination. A review of the facility's policy for Vaccination of Residents dated 9/10/23, included the following under Policy Interpretation and Implementation. All new residents shall be assessed for current vaccination status upon admission. If the resident receives a vaccination, at least the following information shall be documented in the resident's medical record: site of administration, date of administration, lot number of the vaccine (located on the vial), expiration date (located on the vial), and name of the person administering the vaccine. Inquiries concerning the policy should be referred to the Infection Preventionist or the Administrator. On 8/14/24 at 12:08 PM, a surveyor observed Resident #114 wheeled out of the bathroom by a Certified Nursing Assistant. The resident stated that they had about 6 strokes (reduced or blocked blood flow to the brain) and was on insulin because of diabetes. The resident stated that their antidepressant was working well and did not feel depressed. The surveyor reviewed the hybrid (combination of paper and electronic) medical record for Resident #114. According to the Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs), type 2 diabetes mellitus and hypertension (high blood pressure). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #114's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 5/29/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out 15 which indicated the resident's cognition was intact. Further review of the qMDS dated [DATE], under section O0300 A. Is the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected Yes. A review of the electronic Medical Record (eMR) reflected Resident #114 had received Prevnar 13 on 12/20/23. Additionally, the eMR did not reflect historical information of prior pneumococcal immunization received in or out of the facility. A review of the paper-based chart reflected an undated Permission [request] for Pneumococcal Vaccination [administration consent] form. The administration consent form was signed by the resident and did not specify which pneumococcal vaccine was to be administered. A review of the resident's Immunization Record Sheet, under Pneumococcal Vaccine, revealed a blank space for the following: the type of the pneumococcal vaccine administered, previously received, site of administration, date of administration, lot number of the vaccine (located on the vial), expiration date (located on the vial), and the name of the person administering the vaccine. A review of the hybrid medical record did not reflect documentation that PCV15 or PCV20 was offered to the resident or the rationale for administration of Prevnar 13. On 8/21/24 at 11:01 AM, in the presence of the survey team, the Registered Nurse/ Infection Preventionist (RN/IP) stated that she participated with the immunization activities for the facility and identified that the policy on hand was the most recent pneumococcal vaccination policy. On 8/21/24 at 11:33 AM, during an interview with the surveyor, the RN/IP stated that before every influenza season during QAPI (Quality Assurance and Performance Improvement) meetings, the infectious disease doctor, the pharmacy, the DON and medical director discussed immunizations for the residents using the recommendation from the CDC. We (the RN/IP, the Director of Nursing, the Medical Director and the Licensed Nursing Home Administrator) sat down and reviewed the immunization for each new admission. The documentation of the immunization was hybrid and contained the type of vaccine given, the lot number, site of administration and the date the vaccine was administered in the facility. The surveyor asked why the policy did not reflect the current CDC and the ACIP recommendations for the pneumococcal vaccine. The IP had no response. On 8/21/24 at 1:53 PM, in the presence of the survey team, the DON and the LNHA, the surveyor discussed the concern regarding Resident #114 who was not offered pneumococcal vaccination according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 10:35 AM, during an interview with the surveyor, the DON stated that the policy was updated after surveyor inquiry to reflect the current pneumococcal vaccination recommendation. The DON also stated that Prevnar 13 was administered to Resident #114 because that was what the physician ordered. The surveyor asked the DON why there were no documentations made by the staff on the resident's hybrid medical record of the communication made to the physician regarding the current CDC recommendation for pneumococcal vaccine and the physician's rationale for choosing Prevnar 13, which was not in line with the current CDC recommendation for a resident who was over [AGE] years old who had no documented history of prior pneumococcal vaccination. The DON stated moving forward that they will document that the current CDC ACIP recommendations were communicated to the physician. On 8/22/24 at 10:53 AM, during an interview with the survey team, the physician stated that Prevnar 13 was still pertinent and can administer PCV20 as the following dose. A review of the provided facility policy, Charting and Documentation dated/reviewed on 3/7/24, under policy statement reflected: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. No further information was provided. N.J.A.C. 8:39-19.4 (i)