| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315268 | A. Building<br>B. Wing | 03/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brookhaven Health Care Center | 120 Park End Place<br>East Orange, NJ 07018 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>25232<br><br>Based on observations, record review, and interview, the facility failed to ensure that one of eight residents (Resident (R) 38) reviewed for side rails from a sample of 27 residents, had a comprehensive, resident-centered care plan.<br><br>Findings include:<br><br>Review of the facility provided Face Sheet revealed that R38 was readmitted to the<br><br>facility on 06/01/20 with a diagnosis including bipolar, adjustment disorder, disruptive mood disorder, and polyneuropathy.<br><br>Observation of R38's room on 03/05/24 between 6:45 PM-7:15 PM, revealed that R38 was in bed with the bilateral side rails, in the up position.<br><br>Review of the facility provided Order Summary Record dated 03/06/24 revealed, Half side rails when in bed as enabler, repositioning, and for bed mobility, every shift with a start date of 02/04/24.<br><br>Review of the facility provided Quarterly/Annual/Significant Change Nursing Evaluation Packet October 2023, dated 02/04/24, revealed, R38 is non-ambulatory, has difficulty in balance, and poor bed mobility. R38 uses the side rails for positioning.<br><br>Review of the facility provided R38's Care Plan dated 03/18/21 revealed no concern of R38 having difficulty in balance and poor bed mobility and the intervention that R38 used side rails for positioning.<br><br>Interview with the Social Services Director (SSD) on 03/07/24 at 11:34 AM, the SSD indicated that each department does their own care plan.<br><br>Interview with the Director of Nursing (DON) on 03/07/24 at 1:30 PM, the DON confirmed that R38 did not have a comprehensive, resident-centered care plan for the use of side rails on the bed when resident was in the bed for positioning.<br><br>NJAC 8:39-11.2(e)-(i)<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | NJAC 8:39-27.1(a) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232<br><br>36917<br><br>Based on record review, interviews, and review of the facility policy, the facility failed to ensure eight of 27 sampled residents (Resident (R)78, R111, R38, R14, R23, R45, R47, R112) did not have the required participation of all interdisciplinary team members.<br><br>Findings include:<br><br>Review of the facility's policy titled, Comprehensive Care Plans, revised 02/01/22, revealed that the comprehensive care plan would be prepared by an interdisciplinary team, that includes, but is not limited to the attending physician or non-physician practitioner designee involved in the resident's care, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and/or the resident's representative (RR), other appropriate staff or professionals in disciplines as determined by the resident's needs in activities, social services, and therapy staff.<br><br>1. Review of R78's electronic medical record (EMR) Profile tab, indicated R78 was admitted to the facility on [DATE]. R78's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/03/23, revealed R78's Brief Interview of Mental Status (BIMS) score 14 of 15 that indicated resident was cognitively intact.<br><br>Review of R78's EMR, Care plan tab, Interdisciplinary Team (IDT) meeting notes' dated 01/10/24 and dated 10/11/23 revealed no documentation of which staff participated and attended R78's care plan meeting.<br><br>During an interview on 03/04/24 at 11:10 AM, R78 stated that he had not been notified of any care plan meetings and that he had not attended a care plan meeting.<br><br>2. Review of R111's EMR Profile tab, indicates R111 was admitted to the facility on [DATE]. Review of R111's admission MDS with ARD date of 01/24/24, revealed R111's BIMS score 15 of 15 that indicated resident was cognitively intact.<br><br>Review of R111's EMR, Care plan tab, revealed the IDT meeting notes dated 01/24/24, documented nursing staff and the resident had not attended the IDT meeting.<br><br>During an interview on 03/04/24 at 11:51 AM, R111 stated that he had not been notified of any care plan meetings and that he had not attended a care plan meeting.<br><br>3. Review of the facility provided Face Sheet revealed that R38 was readmitted to the<br><br>facility on 06/01/20 with a diagnosis including bipolar, adjustment disorder, disruptive mood disorder, and polyneuropathy.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility provided IDT Meeting Notes, dated 02/23/23 revealed that there was no evidence of a Certified Nursing Assistant (CNA), nurse, and/or physician/designee participating or attending the care plan meeting.<br><br>Review of facility provided IDT Meeting Notes, dated 05/25/23 revealed that there was no evidence of a CNA, nurse, and/or physician/designee attending the care plan meeting.<br><br>Review of facility provided IDT Meeting Notes, dated 08/24/23 revealed that there was no evidence of a CNA, physician/designee, activity director (AT), and/or therapy attending the care plan meeting.<br><br>Review of facility provided IDT Meeting Notes, dated 02/15/24 revealed that there was no evidence of a CNA, activity department, nurse, and/or physician/designee attending the care plan meeting.<br><br>Review of the facility provided Progress Notes dated 01/23 through 03/07/24 revealed no evidence of the unit manager getting CNA input for care plan meetings.<br><br>4. Review of R14's Admission Record located in the EMR under the Profile tab indicated admitted on 08/22/14 with diagnoses of hypertensive chronic kidney disease and end stage renal disease.<br><br>Review of R14's quarterly MDS located in the EMR under the MDS tab with an ARD of 12/21/23 included a BIMS score of 15 out of 15 which indicated R14 was cognitively intact.<br><br>Review of R14's IDT Meeting Notes dated 10/12/23, 07/27/23, 04/27/23, and 01/26/23 located in the EMR under the Assessments tab revealed R14's IDT meetings had no documentation as to which staff, resident or RR attended the care plan meeting.<br><br>5. Review of R23's Admission Record located in the EMR under the Profile tab indicated admitted [DATE] with diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.<br><br>Review of R23's quarterly MDS located in the EMR under the MDS tab with an ARD of 11/09/23 included a BIMS score of 13 out of 15 which indicated R23 was cognitively intact.<br><br>Review of R23's IDT Meeting Notes located in the EMR under the Assessments tab revealed the IDT meeting dated 02/15/24 failed to include the nursing department. The IDT meeting notes for 06/15/23 and 12/22/22 were blank in that the document did not indicate which staff, resident or RR attended the meeting and the meeting dated 03/16/23 only included notation from the nursing department without proof of dietary, social services, or activities being included in the care plan meeting.<br><br>6. Review of R45's Admission Record located in the EMR under the Profile tab indicated admitted [DATE] with a primary diagnosis of gastrostomy.<br><br>Review of R45's significant change in status MDS located in the EMR under the MDS tab with an ARD of 01/14/24 included a BIMS score of 99 which indicated R45 had severe cognitive impairment.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R45's IDT Meeting Notes located in the EMR under the Assessments tab revealed the IDT meeting notes dated 05/04/23 were blank in that the document did not indicate which staff, resident or RR attended the meeting. There was no documentation indicating a meeting was held in August 2023, and 10/26/23 document did not indicate which staff, resident or RR attended the meeting was blank as well. The IDT meeting notes for 01/25/24 failed to include the nursing department.<br><br>7. Review of R47's Admission Record located in the EMR under the Profile tab indicated admitted [DATE] with diagnosis of polyosteoarthritis.<br><br>Review of R47's quarterly MDS located in the EMR under the MDS tab with an ARD of 12/27/23 included a BIMS score of 15 out of 15 indicating she was cognitively intact.<br><br>Review of R47's IDT Meeting Notes located in the EMR under the Assessments tab revealed the IDT meeting notes dated 01/12/23, 04/13/23, 07/13/23, and 01/11/24 failed to include notation from dietary, social services, or activities of their attendance at the care plan meeting.<br><br>8. Review of R112's Admission Record located in the EMR under the Profile tab indicated admitted [DATE] with diagnosis of cerebral palsy.<br><br>Review of R112's admission MDS located in the EMR under the MDS tab with an ARD of 01/20/24 included a BIMS score of 0 out of 15 which indicated R112 was not able to participate in the interview.<br><br>Review of R112's IDT Meeting Notes located in the EMR under the Assessments tab revealed the IDT meeting note dated 01/25/24 failed to include the nursing department participation in the care plan meeting.<br><br>During an interview on 03/07/24 at 3:16 PM with the Director of Nursing (DON) confirmed<br><br>that R14, R78, R111 and R38's IDT meetings did not indicate which staff, resident or RR attended the meeting.<br><br>R23's IDT meeting dated 02/15/24 failed to include the nursing department. The IDT meeting notes for 06/15/23 and 12/22/22 were blank, and the meeting dated 03/16/23 only included notation from the nursing department without proof of dietary, social services, or activities being included in the care conference meeting.<br><br>R45's IDT meeting notes dated 05/04/23 and 10/26/23 were blank, IDT meeting notes for 01/25/24 failed to include the nursing department, and no IDT notes for August of 2023 were located.<br><br>R47's IDT meeting notes dated 01/12/23, 04/13/23, 07/13/23, and 01/11/24 failed to include notation from dietary, social services, or activities.<br><br>R112's IDT meeting note dated 01/25/24 failed to include the nursing department.<br><br>Interview with CNA1 on 03/06/24 at 10:15 AM, CNA1 indicated that CNAs went to care plan meetings at one time; however, it has been a while and confirmed that currently, CNAs do not attend care plan meetings.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 03/06/24 at 2:03 PM, Registered Nurse (RN) 2 indicated the key players in care plan meetings are unit manager, dietician, therapy, social services, family, and resident. If the resident and/or family want to speak with the physician, then the physician will be contacted during the meeting.<br><br>Interview on 03/07/24 at 11:34 AM, the Social Services Director (SSD) stated that the resident, resident representative (RR), therapy, dietary, recreational attend when able and that the unit manager come and CNA can come if they want to, and others as needed such as hospice attend the care plan meetings.<br><br>During an interview on 03/07/24 at 3:16 PM, the DON stated that her expectation was for anyone attending the meeting to sign an attendance sheet that was kept by the Social Services Director and that all IDT meeting notes would be located in the EMR under the Assessments tab titled, IDT Meeting Note.<br><br>40824<br><br>NJAC 8:39-11.2(e)(f)(h) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824<br><br>Based on observations, record review, interview and facility policy review, the facility failed to follow physician orders for one of 11 residents (Resident (R)74) reviewed for physician orders. Specifically, the facility failed to apply R74's antiembolism hose to her left leg per the physician orders.<br><br>Findings include:<br><br>Review of the facility's policy provided by the facility titled, Physician Orders revised 02/2022 indicated It is the policy of this facility to secure physician orders for care and services for residents as required by .federal law. Physician orders will be dated and signed according to .federal guidelines .<br><br>Review of R74's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab indicated admitted [DATE] with a primary diagnoses of hemiplegia and hemiparesis following a cerebrovascular incident affecting the left non-dominant side.<br><br>Review of R74's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 01/04/24 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact.<br><br>Review of R74's Clinical Physician Orders located in the EMR under the Orders tab included an order dated 02/02/23 for antiembolism hose to be applied to the left leg daily (9:00 AM) and removed at night.<br><br>During an observation and interview on 03/04/24 at 12:06 PM; on 03/05/24 at 2:46 PM; on 03/06/24 at 2:33 PM; on 03/07/24 at 8:42 AM, R74 was lying in bed and stated that she was not aware that antiembolism hose were to be applied.<br><br>During an observation and interview on 03/07/24 at 11:34 AM, R74 was lying in bed and stated that she was experiencing discomfort to left lower extremity. R74 pointed to the edema of her left foot. She was not aware that she had a current physician's order for compression stockings and stated that no one had put them on her in quite some time.<br><br>During an interview on 03/06/24 at 4:01 PM, Certified Nursing Assistant (CNA2) stated to her knowledge R74 did not wear antiembolism hose. CNA2 stated she had never applied hose to R74's left lower extremity and had never seen any in her room.<br><br>During an interview on 03/07/24 at 12:00 PM, Licensed Practical Nurse (LPN7) verified R74 had orders for antiembolism hose and that she had signed off in the EMR that they had been applied, but she had not put them on R74's left leg. When LPN7 was asked why the task had been signed off she stated that she thought the nurse aide was going to put them on but did not verify.<br><br>During an interview on 03/07/24 at 12:00 PM, CNA4 stated she was not sure if antiembolism hose were part of R74's daily tasks but that she had not put any hose on her in the past.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/07/24 at 7:06 PM, the Director of Nursing (DON) was made aware of R74 not wearing compression stockings and that there was no documentation to indicate if the stockings had been offered or refused. The DON confirmed that R74 had orders in place for antiembolism hose since 02/02/23.<br><br>NJAC 8:39-27.1 |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824<br><br>Based on observations, record review, interview, and facility policy review, the facility failed to follow physician orders for one of 11 residents (Resident (R)74) reviewed for following physician orders. Specifically, the facility failed to apply R74's left upper extremity splints or provide restorative nursing range of motion (Passive Range of Motion (PROM) on Left Upper Extremity (LUE) and Left Lower Extremity (LLE) and Active Range of Motion (AROM) to Right Upper Extremity (RUE) and Right Lower Extremity (RLE) per the physician orders.<br><br>Findings include:<br><br>Review of the facility's policy titled Functional Maintenance/Restorative Nursing Program revised 08/2023 indicated, .4. The primary caregiver/designated CNA [certified nursing assistant] will be informed by written documentation as a form filled by therapy dept [department] or restorative nurse indicating that the resident has been placed on the Restorative Nursing or Functional Maintenance program. 5. The Unit Manager/ Nurse will record this change in care needs in PCC [electronic medical record] under the tasks and the CNA assigned to care for the resident will be responsible for carry [sic] out the instructions and to implement the plan .<br><br>Review of R74's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab indicated admitted [DATE] with a primary diagnoses of hemiplegia and hemiparesis following a cerebrovascular incident affecting the left non-dominant side.<br><br>Review of R74's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 01/04/24 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated resident was cognitively intact. Additionally, the MDS indicated that no PROM had been provided, one day of AROM had been provided, and no splint or brace assistance had been provided.<br><br>Review of R74's Care Plan located in the EMR under the Care Plan tab, updated 01/01/24, indicated R74 had the potential for alteration in functional mobility and Activities of Daily Living (ADLs) performance related to generalized weakness. Interventions included AROM on RUE and RLE 10 repetitions times three sets each or as tolerated, passive PROM on LUE and LLE 10 repetitions times three sets each or as tolerated, application of left elbow splint for four hours, or as tolerated, and left resting hand splint for four hours.<br><br>Review of R74's Clinical Physician Orders located in the EMR under the Orders tab included an order dated 01/17/24 included restorative nursing program to apply left elbow and left resting hand splint for four hours or as tolerated, PROM on LUE and LLE ten repetitions times three sets each or as tolerated, and AROM to RUE and RLE ten repetitions times three sets each or as tolerated.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R74's OT [Occupation Therapy] Evaluation & Plan of Treatment dated 06/20/22-09/15/22 and provided by the Certified Occupational Therapist Assistant (COTA) indicated the OT team was working with the resident to wear a left resting hand splint for four hours without signs or symptoms of redness or skin irritation to maintain joint/skin integrity as of 07/03/22. Additionally, the therapy department was working with R74 to tolerate a left elbow extension splint for four hours without signs or symptoms of redness or skin irritation to maintain joint/skin integrity as of 07/03/22. The goal was later revised on 12/13/22 for the resident to wear splints for at least eight hours.<br><br>Review of R74's Therapy In-Service Form dated 12/14/22 and provided by the COTA revealed Certified Nursing Assistants (CNAs) were in-serviced regarding active range of motion on RUE and RLE 10 repetitions for three sets each or as tolerated. Passive ROM on LUE and LLE 10 repetitions for three sets each or as tolerated. Apply left elbow extension splint for four hours or as tolerated, skin check before and after wearing splint. Apply left resting hand splint for four hours, check skin before and after wearing splint. Rolling side to side with maximum assist for five repetitions with 30 seconds hold, daily, incorporated into morning and evening care in order to provide pressure relief and decrease risk for pressure sores.<br><br>Review of R74's CNA documentation POC [Point of Care] Response History located in the EMR under the Tasks tab dated 02/05/24-03/05/24 revealed she had not received assistance with AROM, PROM, or splint application for 22 (02/06/24, 02/08/24, 02/10/24, 02/12/24, 02/14/24, 02/16/24-02/18/24, 02/20/24-02/29/24, 03/02/24-03/05/24) of 30 days.<br><br>During an interview on 03/04/24 at 12:06 PM, R74 stated she had not received any range of motion assistance from staff in a long time.<br><br>During an observation and interview on 03/07/24 at 11:34 AM, R74 stated that she was experiencing ongoing discomfort to left lower extremity and edema to her foot. R74 stated that she had not consistently received restorative nursing assistance from nursing staff since she was moved to the third floor (July 2022).<br><br>During an interview on 03/06/24 at 4:01 PM, CNA2 stated she had never provided R74 restorative nursing care.<br><br>During an interview on 03/07/24 at 12:00 PM, Licensed Practical Nurse (LPN7) verified R74 had orders for restorative nursing and that she had signed off in the EMR that AROM and PROM were being done, but she had not confirmed the activity, and was not aware that it was not being done on a consistent basis. When LPN7 was asked why the task had been signed off she stated that she thought the nurse aide was going to perform the tasks but did not verify.<br><br>During an interview on 03/07/24 at 12:00 PM, CNA4 stated she was not sure if restorative nursing tasks were included R74's daily tasks but that she had not done any PROM in quite a while because she thought the restorative nursing aide would do it. She was not aware that the facility no longer had restorative nursing staff.<br><br>During an interview on 03/07/24 at 7:06 PM, the Director of Nursing (DON) was made aware of R74 not receiving restorative nursing assistance. The DON confirmed that R74 had orders in place for restorative nursing program and that the facility no longer had a restorative nursing assistant and that her expectation was that the CNAs would perform restorative nursing program (RNP) tasks.<br><br>(continued on next page) |

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|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | NJAC 8:39-27.1<br><br>NJAC 8:39-27.2(m) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315268 | A. Building<br>B. Wing | 03/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brookhaven Health Care Center | 120 Park End Place<br>East Orange, NJ 07018 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824<br><br>40902<br><br>Based on observation, interview, record review and policy review, the facility failed to ensure staff followed physician orders related to oxygen administration for one (Resident (R) 19 of one sampled residents. In addition, the facility failed to assess for one of one sampled residents reviewed for nebulizer treatments (R221) the resident's vital signs or lung sounds before or after administering the nebulizer medication.<br><br>Findings include:<br><br>1. Review of R19's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnosis of pneumonia.<br><br>Review of R19's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 01/18/24, revealed a Brief Interview for Mental Status (BIMS), score of 03 out of 15 which indicated resident had severe cognitive impairment. Further review of the MDS revealed R19 received continuous oxygen therapy on admission and while a resident.<br><br>Observations on 03/04/24 at 11:30 AM, 03/05/24 at 5:30 PM and 03/06/24 at 2:35 PM revealed R19 wearing a nasal cannula and the oxygen setting was at 2 liters per minute (LPM).<br><br>Review of R19's Care Plan, located under the Care Plan tab of the EMR dated 01/12/24, revealed the resident has Chronic Obstructive Pulmonary Disease (COPD) and is on oxygen.<br><br>Review of R19 Physician Orders located under the Orders tab of the EMR dated 01/12/24, revealed an order for continuous oxygen at 3 LPM via nasal cannula.<br><br>Review of R19 Treatment Administration Record (TAR) located under the Orders tab of the EMR dated March 2024 revealed oxygen at 3 LPM via nasal cannula continuously was signed off on 03/06/24 by Licensed Practical Nurse (LPN) 5 for the 7 AM to 3 PM shift.<br><br>During an interview on 03/06/24 at 2:37 PM, LPN5 said that R19's oxygen should be set at 2 LPM. He stated that he checked this morning, and it was at set at 2 LPM. LPN 2 verified R19 setting was at 2 LPM and stated that he was unaware R19's physician order was for 3 LPM.<br><br>During an interview on 03/07/24 at 1:29 PM, the Director of Nursing (DON) said when a resident was on oxygen, she expected staff to follow the physician order exactly.<br><br>Review of the facility's policy titled Respiratory Practices dated 02/2024 revealed, Oxygen therapy via nasal cannula is administered as ordered by a physician and includes correct flow rate.<br><br>2. Review of the facility's policy titled, Nebulizer revised 04/2008 indicated the procedure included, . note pre-treatment data such as pulse and breath sounds . note post treatment data (pulse, breath sounds and any side effects) and record in the medical record .<br><br>(continued on next page) |

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| Brookhaven Health Care Center | 120 Park End Place<br>East Orange, NJ 07018 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R221's Admission Record located in the EMR under the Profile tab indicated R221 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of end stage renal disease.<br><br>Review of R221's admission MDS located in the EMR under the MDS was not completed due to admission on 02/16/24 and re-admission on 03/06/24.<br><br>Review of R221's Care Plan located in the EMR under the Care Plan tab, updated 02/29/24 included shortness of breath related to heart failure, but did not include nebulizer treatments that were implemented on 03/07/24.<br><br>Review of R221's Clinical Physician Orders located in the EMR under the Orders tab included an order dated 03/07/24 for ipratropium-albuterol solution (nebulizer treatment for shortness of breath) 0.5mg (milligram)-2.5mg (3) mg/3ml (milliliter), give three milliliters every four hours for shortness of breath, pre and post lung sounds, and pre/post pulse, respirations, and oxygen level.<br><br>During an observation and interview on 03/07/24 at 10:09 AM, LPN4 revealed that she did not check R221's pulse, respirations, or oxygen saturation before or after nebulizer administration, nor did she listen to his lung sounds. LPN4 did not give a reason as to why she did not perform pre/post assessments but stated that she should have checked his vital signs and lung sounds before and after administering the medication. LPN4 stated she was getting ready to give him his oral medications and would check his vital signs and lung sounds. LPN4 was not sure if not checking lung sounds or not checking vital signs was considered a medication error.<br><br>During an interview on 03/07/24 at 3:44 PM, the DON was made aware of LPN4 not checking vital signs or checking lung sounds before or after administering nebulizer medication to R221. The DON confirmed that it was her expectation that all nurses follow physician orders and check lung sounds and vital signs before and after nebulizer medication administration.<br><br>NJAC 8:39-27.1 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232<br><br>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that side rails were maintained properly for seven of seven residents (Resident (R)7, R14, R38, R45, R96, R101, and R112) reviewed for side rails out of 27 sampled residents. This had the potential to cause entrapment which could potentially cause death.<br><br>Findings include:<br><br>Review of the facility's policy titled Proper Use of Side Rails, revised date 02/24, revealed, .3. If a bed or side rail is used, the facility must ensure correct installation, use and maintenance of bed rails, including, but not limited to, the following elements .c. Ensure that the bed's dimensions are appropriate for the resident's size and weight. d. Follow the manufacturer's recommendations and specifications for installing and maintaining bed rails .17. Inspection, evaluation, maintenance, and upgrade of equipment (beds/mattresses/side rails) must be completed prior to use to identify and remove potential fall and entrapment hazards and appropriately match the equipment to resident needs, considering all relevant risk factors.<br><br>1. Review of the facility provided Face Sheet revealed that R38 was readmitted to the<br><br>facility on 06/01/20 with diagnoses including bipolar, adjustment disorder, disruptive mood disorder, and polyneuropathy.<br><br>Review of the facility provided Order Summary Record dated active orders as of 03/06/24, revealed, Half side rails when in bed as enabler, repositioning, and for bed mobility., every shift with start date of 02/04/24.<br><br>2. Review of R7's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab indicated he was admitted to the facility on [DATE] with diagnosis of metabolic encephalopathy.<br><br>Review of R7's Significant Change in Status MDS located in the EMR under the MDS tab with an ARD of 01/19/24 included a BIMS score of 03 indicating she had severe cognitive impairment.<br><br>Review of R7's Care Plan located in the EMR under the Care Plan tab, initiated on 08/01/23 included use of side rails for positioning.<br><br>Review of R7's Admission/Readmission Nursing Evaluation Packet located in the EMR under the Assessment tab dated 01/12/24 indicated the resident wanted side rails as an enabler to promote independence and the side rails did not prohibit resident's mobility or freedom of movement.<br><br>Review of R7's Clinical Physician Orders located in the EMR under the Orders tab dated 02/01/24 included half side rails when in bed as enabler, repositioning, and for bed mobility.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Review of R14's Admission Record located in the EMR under the Profile tab indicated he was admitted to the facility on [DATE] with diagnoses of hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease.<br><br>Review of R14's Five Day MDS located in the EMR under the MDS tab with an ARD of 12/21/23 included a BIMS score of 15 indicating he was cognitively intact.<br><br>Review of R14's Care Plan located in the EMR under the Care Plan tab, revised on 08/02/19 included use of side rails for positioning.<br><br>Review of R14's Admission/Readmission Nursing Evaluation Packet located in the EMR under the Assessment tab dated 12/21/23 indicated the resident wanted side rails as an enabler to promote independence and the side rails did not prohibit resident's mobility or freedom of movement.<br><br>Review of R14's Clinical Physician Orders located in the EMR under the Orders tab dated 02/01/24 included half side rails when in bed as enabler, repositioning, and for bed mobility.<br><br>4. Review of R45's Admission Record located in the EMR under the Profile tab indicated he was admitted to the facility on [DATE] with diagnosis of encounter for attention to gastrostomy.<br><br>Review of R45's Significant Change in Status MDS located in the EMR under the MDS tab with an ARD of 01/14/24 included a BIMS score of 99 indicating she had severe cognitive impairment.<br><br>Review of R45's Care Plan located in the EMR under the Care Plan tab, revised on 10/17/23 included use of side rails for positioning.<br><br>Review of R45's Admission/Readmission Nursing Evaluation Packet located in the EMR under the Assessment tab dated 12/29/23 indicated the resident wanted side rails as an enabler to promote independence and the side rails did not prohibit resident's mobility or freedom of movement.<br><br>Review of R45's Clinical Physician Orders located in the EMR under the Orders tab dated 02/01/24 included quarter side rails when in bed as enabler, repositioning, and for bed mobility.<br><br>5. Review of R96's Admission Record located in the EMR under the Profile tab indicated he was admitted to the facility on [DATE] with diagnosis of multiple myeloma not having achieved remission.<br><br>Review of R96's Significant Change in Status MDS located in the EMR under the MDS tab with an ARD of 01/17/24 included a BIMS score of seven indicating he had severe cognitive impairment.<br><br>Review of R96's Care Plan located in the EMR under the Care Plan tab, revised on 04/13/23 included use of side rails for positioning.<br><br>Review of R96's Admission/Readmission Nursing Evaluation Packet located in the EMR under the Assessment tab dated 01/11/24 indicated the resident wanted side rails as an enabler to promote independence and the side rails did not prohibit resident's mobility or freedom of movement.<br><br>Review of R96's Clinical Physician Orders located in the EMR under the Orders tab dated 01/11/24 included quarter side rails when in bed as enabler and for bed mobility.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 03/04/24 at 10:33 AM R96's left side rail was noted to be loose. R96 stated he had reported the loose rail on multiple occasions, but no one had come to tighten it.<br><br>6. Review of R101's Admission Record located in the EMR under the Profile tab indicated he was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.<br><br>Review of R101's Care Plan located in the EMR under the Care Plan tab, revised on 12/15/23 included use of side rails for positioning.<br><br>Review of R101's Admission/Readmission Nursing Evaluation Packet located in the EMR under the Assessment tab dated 12/15/23 indicated the resident wanted side rails as an enabler to promote independence and the side rails did not prohibit resident's mobility or freedom of movement.<br><br>Review of R101's Clinical Physician Orders located in the EMR under the Orders tab dated 02/01/24 included half side rails when in bed as enabler for bed mobility.<br><br>7. Review of R112's Admission Record located in the EMR under the Profile tab indicated he was admitted to the facility on [DATE] with diagnosis of cerebral palsy.<br><br>Review of R112's Admission MDS located in the EMR under the MDS tab with an ARD of 01/20/24 included a BIMS score of 0, R112 was not able to participate in the interview.<br><br>Review of R112's Care Plan located in the EMR under the Care Plan tab, revised on 01/13/24 included use of side rails for positioning.<br><br>Review of R112's Admission/Readmission Nursing Evaluation Packet located in the EMR under the Assessment tab dated 01/13/24 indicated the resident wanted side rails as an enabler to promote independence and the side rails did not prohibit resident's mobility or freedom of movement.<br><br>Review of R112's Clinical Physician Orders located in the EMR under the Orders tab dated 02/01/24 included half side rails when in bed as enabler, repositioning, and for bed mobility.<br><br>During an interview on 03/04/24 at 11:30 AM, R112's left side rail was loose. Resident's cognitive status prevented him from confirming status of side rail or if he used them for repositioning.<br><br>During an interview on 03/05/24 at 5:00 PM, the Administrator stated that the Maintenance Director (MD) and the maintenance team were responsible for ensuring that bed rails were properly maintained and inspected.<br><br>During an observation and interview on 03/05/24 6:45 PM-07:15 PM, MD performed bed rounds and reported that every week two rooms are chosen on each floor for bed rail inspections, some beds have a pin lock with no bolt to tighten the rails, and other beds have a round knob that allows the rails to be tightened, and confirmed the following loose side rails:<br><br>R7's bilateral side rails were loose.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R14's left side rails were loose.<br><br>R45's bilateral side rails were loose.<br><br>R96's right side rail was loose.<br><br>R101's left side was loose.<br><br>R112's bilateral side rails were loose.<br><br>R38's side rails were loose.<br><br>40824<br><br>NJAC 8:39-27.1(a) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902<br><br>Based on observation, interview, record review and policy review, the facility failed to ensure nursing staff properly stored nebulizer masks when not in use for one (Resident (R) 19 of one sampled residents.<br><br>Findings include:<br><br>Review of R19's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnosis of pneumonia.<br><br>Review of R19's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 01/18/24, revealed a Brief Interview for Mental Status (BIMS), score of 03 out of 15 which indicated resident had severe cognitive impairment.<br><br>Observations on 03/04/24 at 11:30 AM, 03/05/24 at 5:30 PM and 03/06/24 at 2:35 PM revealed R19's nebulizer mask was placed inside a bag on the dresser by R19's bed. The bag was not sealed or closed.<br><br>Review of R19's Care Plan, located under the Care Plan tab of the EMR dated 01/12/24, revealed, The resident had periods of shortness of breath. Administer nebulizer treatment .<br><br>During an observation and interview on 03/06/24 at 2:37 PM, Licensed Practical Nurse (LPN)5 stated the nebulizer mask went in a plastic bag that was dated and the bag was ziplocked closed to prevent air from getting in which was an infection control issue. LPN5 observed R19's nebulizer mask in an unsealed bag and stated that the tubing was still attached to the mask so there was no way to seal the zip lock bag.<br><br>During an interview on 03/06/24 at 3:17 PM, LPN 6 said he was the floor supervisor for both the 2nd and 3rd floors and that nebulizer masks should be kept in a plastic bag that was closed and sealed to prevent possible infection control issues.<br><br>During an interview on 03/07/24 at 1:29 PM, the Director of Nursing (DON) said nebulizer masks should be stored in a sealed plastic bag for infection control purposes.<br><br>Review of the facility's policy titled Infection Control dated 01/2024 revealed, when not in use store masks and cannula in plastic bags labeled with the resident's name and date.<br><br>NJAC 8:39-19.4(k) |