STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Woodlands	1400 Woodland Ave Plainfield, NJ 07060

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observations, interviews, record review, and facility policy review, the facility failed to provide one of 27 sampled residents (Resident (R) 87) a dignified dining experience. Specifically, the facility failed to provide regular silverware to R87, who was not assessed to be a danger to herself or others, for 14 months. Findings include: During an observation on 01/29/24 at 12:28 PM, R87 was in bed with her lunch tray in front of her. R87 was using plastic silverware to eat. When interviewed, R87 stated she did not know why she was provided plastic utensils to eat her meal. During an observation on 01/30/24 at 9:58 AM, R87 was in bed with her breakfast tray in front of her. R87 stated breakfast was great. The resident had eaten 100 % of her meal using plastic utensils. When interviewed, R87 stated, I've never had anything but plastic. During an observation on 01/30/24 at 12:07 PM, R87 was in bed with her lunch tray in front of her. R87 had plastic utensils provided to eat her meal. When interviewed, R87 stated, I don't know why I have plastic, I'm not suicidal. During an observation on 01/31/24 at 8:23 AM, R87 was in bed with her breakfast tray in front of her. R87 stated look, I don't know how I got them. R87 was observed pointing at the silverware on her tray. When interviewed, R87 stated, it's much easier to eat with these than plastic. During an observation on 02/01/24 at 8:32 AM, R87 was observed to have regular silverware on her breakfast tray. R87 stated, I'm very happy to have silverware. Review of R87's Census located under the Clinical tab in the electronic medical record (EMR) revealed R87 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, and anxiety disorder. Review of R87's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R87 was cognitively intact. Review of the Mood and Behavior sections noted no serious mental illness and no behaviors toward self or others. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nurses' progress notes, located in the EMR Clinical tab and dated 11/16/22, revealed R87 is on monitoring every 15mins [minutes], no abnormal behavior noted. All medications given as ordered, no adverse reactions noted. Safety precautions in place Review of the 11/16/22 Psychiatry Notes,: located under the EMR Miscellaneous tab, revealed Psych [psychiatric] Eval [evaluation] req.[requested] . S/P [status post] Hosp [hospital] (Intracerebral [NAME]). Per records resident w/SI [with suicidal ideation] during hosp stay-Seen by Psych. Nursing staff report no behaviors/concerns. AAOX3 [alert and oriented times person, place, time], calm, cooperative. Denies feeling depressed or hopeless. Denies SI/HI [suicidal/homicidal ideation]. No plan/intent. Expresses frustration being in facility. Expresses desire to go home. Sleep-Fair. Appetite-Adequate. Energy-Good. Denies A/V/H [auditory/visual/hallucinations]. No psychosis. Plan noted Monitor & Document Resident's Mood & Behaviors. Report any concerns to Psychiatry. Review of Individual psychotherapy progress notes, located and the EMR Miscellaneous tab, dated 01/13/24, 12/20/23, 11/07/23, 07/07/23 revealed no indication of SI/HI. Review of the Every 15 minute monitoring logs, provided by the facility, beginning at 5:00 PM on 11/15/22 to 3:00 PM on 11/16/23 revealed no behaviors. No other monitoring in place for behavioral needs Review of R87's care plan, revised on 01/13/24 and located under the Clinical tab, revealed R87 did not have an intervention for plastic utensils. During an interview on 01/31/24 at 11:13 AM, the Social Service Director (SSD) stated she did not know why R87 was served her meals with plastic utensils. During an interview on 01/31/24 at 2:04 PM, the Dietary Manager (DM) stated, when the resident first came in she had threatened others, nurses told dietary no silverware, never told anything different. During an interview on 02/01/24 at 8:46 AM, Unit Manager (UM) 1 said she did not know that R87 was served with plastic utensils, she's not a danger to anyone. Review of the facility's Suicide Assessment policy and procedure, provided by the Director of Nurses, dated 01/10/23, revealed Residents will be assessed for suicide risk upon admission and as indicated. The facility social worker or designee will conduct a medical record review and then interview the resident regarding any risk factors that have been identified. Protective factors will be explored with the resident as well. NJAC 8:39-17.2

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513 Based on record review, interview, review of the Resident Assessment Instrument (RAI) manual and policy review, the facility failed to ensure ten residents out of 27 sampled resident's (Resident (R)16, R62, R6, R42, R44, R97, R72, R78, R2, R15) Minimum Data Set (MDS) assessments were transmitted in a timely manner. Findings include. Review of the facility policy titled, MDS Completion and Submission Timeframes, dated 10/22/23, revealed, . Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes . The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS [Center for Medicare/Medicaid Services] QIES [Quality Improvement & Evaluation System] Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines . Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . Review of the CMS Long-term Facility Assessment Instrument 3.0 User's Manual, version 1.18.11, dated 10/23/23, revealed, . Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS . RAI OBRA [Omnibus Budget Reconciliation Act]-required assessment summary for quarterly, significant change, and annual, and discharge assessments are no later than ARD [assessment reference date] + 14 calendar days . 1. Review of the annual MDS, located in the MDS tab of the electronic medical record (EMR), with an ARD date of 12/17/23 revealed R16 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be export ready and was to be submitted by 01/21/24. The assessment was 10 days late in being submitted. 2. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 12/22/23 revealed R62 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be export ready and should have been submitted on 01/19/24. The assessment was 12 days late in being submitted. 3. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 12/20/23 revealed R6 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be submitted 14 days late on 01/17/24 and should have been submitted on 01/03/24. 4. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 12/25/23 revealed R42 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be in progress. The assessment should have been submitted on 01/08/24. The assessment was 23 days late in being submitted. 5. Review of the annual MDS located in the MDS tab of the EMR with an ARD of 12/22/23 revealed R44 admitted to the facility on [DATE]. On 01/31/24, the annual MDS was identified to be in progress. The assessment should have been submitted on 01/05/24. The assessment was 26 days late in being submitted. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the quarterly MDS located in the MDS tab of the EMR with ARD of 12/24/23 revealed R97 was admitted to the facility on [DATE]. On 01/31/24, the quarterly MDS was identified to be export ready and was to be submitted by 01/21/24. The assessment was 10 days late in being submitted. 7. Review of the significant change MDS located in the MDS tab of the EMR with an ARD of 12/26/23, revealed R72 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be export ready and was to be submitted by 01/20/24. The assessment was 11 days late in being submitted. 8. Review of the annual MDS located in the MDS tab of the EMR with an ARD of 12/21/23 revealed R78 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be export ready and was to be submitted by 01/25/24. The assessment was six days late in being submitted. 9. Review of the annual MDS located in the MDS tab of the EMR with an ARD of 12/23/23 revealed R2 was admitted to the facility on [DATE]. On 01/31/24, the assessment was identified to be export ready and was to be submitted by 01/27/24. The assessment was four days late in being submitted. 10. Review of the significant change MDS located in the MDS tab of the EMR with an ARD of 12/24/23 revealed R15 was admitted to the facility on [DATE]. On 01/31/24, the assessment was to export ready and was to be submitted on 01/28/24. The assessment was three days late in being submitted. During an interview on 01/31/24 at 8:37 AM, the MDS Coordinator (MDSC) was asked why the assessments were not submitted in a timely manner. She stated, I am the only one doing MDS assessments. I know they are not submitted but I have been waiting on social services as they have not been able to input their information timely. NJAC 8:39-11.2(3)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observations, interviews, record review, and facility policy review, the facility failed to develop a baseline care plan for five of 27 residents (Resident (R) 159, R109, R160, 45, and R32) to include interventions to address current resident needs. Findings include: 1. Review of R159's Census, located in the electronic medical record (EMR) under the Clinical tab, revealed R159 was admitted to the facility on [DATE] and had diagnoses that included pressure ulcer of left buttock, stage 2; pressure ulcer of left hip, stage 2; non-pressure chronic ulcer of right ankle with unspecified severity; non-pressure chronic ulcer of other part of right foot with unspecified severity. During an observation on 01/29/24 at 12:46 PM, R159 was lying in bed groaning. R159 appeared frail and distressed. When interviewed, R159 stated, I don't know what to do, oh help me, what do I do? R159 was observed to have three separate bandages on her right arm, one above her elbow, one below her elbow, and one near her wrist. R159 was not interviewable. During an observation on 01/30/24 at 9:58 AM, R159 was asleep in bed. R159's right arm was observed to have three separate bandages on. During an observation on 01/31/24 at 8:31 AM, R159 was in bed and stated, no, oh, oh. Unit Manager (UM) 1 was assisting R159 to take sips of thickened orange juice from a spoon. R159 was observed to say, no, and put her napkin in front of her mouth. R159's right arm was observed without bandages. Three closed skin tears were noted, uncovered on her right arm. The UM1 stated, her skin is so thin, she has several skin problems. Review of R159's baseline care plan, initiated 01/26/24, revealed focus areas identified as: moderate risk for falls; enhanced barrier precautions related to wounds; history of urinary tract infection; use of antidepressant medication; severe protein calorie malnutrition due to moderate body fat loss and muscle mass loss; potential/actual impairments to skin integrity related to fragile skin and immobility. There was not a focus concern to address R159's pain and discomfort due to the pressure ulcers and skin wounds. During an interview on 02/01/24 at 12:48 PM with the Director of Nursing (DON) and UM1, the DON stated, it is our expectation that pain would be on the baseline care plan. 2. Review of R109's Census located in the EMR under the Clinical tab revealed R109 was admitted to the facility on [DATE] and had diagnoses that included toxic encephalopathy, epilepsy, Alzheimer's disease, syncope and collapse, difficulty walking, and lack of coordination. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/29/24 at 12:56 PM, R109 was in her room seated in her wheelchair while Family Member (F4) assisted her to eat a dessert. F4 stated, I'm here every day, [R109] can't be left alone, I'm afraid she will fall and get hurt like at the hospital. F4 stated, she can't speak for herself anymore, she has a lot of pain in her right arm from the fall. F4 touched R109's right hand/arm, R109 said, ow, ow, and pulled her right hand/arm away. Review of R109's baseline care plan, initiated 01/09/24, revealed focus areas identified as: dependent on staff for meeting emotional, intellectual, physical, and social needs related to disease process; at risk for falls; requires enhanced barrier precautions related to sacral wound; resident has a seizure disorder; at risk for malnutrition; and resident has potential/actual impairment to skin. There was not a focus concern to address R109's right arm pain or R109's communication needs. In an interview on 02/01/24 at 12:48 PM with the DON and UM1, the DON stated, it is our expectation that pain, and communication would be on the baseline care plan. 3. Review of R160's Census located in the EMR under the Clinical tab revealed R160 was admitted to the facility on [DATE] and had diagnoses that included encounter for surgical aftercare following surgery on the digestive system and wedge compression fracture of the first lumbar vertebra. During an observation on 01/29/24 at 12:30 PM, R160 was in her room in her wheelchair with her lunch tray in front of her. R109 spoke only Spanish, rubbed her stomach, raised her shoulders, and stated, no English. During an observation on 01/31/24 at 8:28 AM, R160 was sitting upright in bed with her breakfast tray in front of her. R160 pointed to her orange juice and smiled, pointed to her plate, and shook her head no, and placed her hand on her stomach. Review of R160's baseline care plan, initiated on 01/25/24, revealed focus areas identified as: independent for meeting emotional and social needs; resident has diabetes mellitus; resident has an alteration in gastrointestinal status; at risk for malnutrition related to varied intake. There was not a focus concern to address R160's pain or R160's communication needs. During an interview on 01/31/24 at 1:25 PM, R160 (with R160's three Family Members (F1, F2, and F3) present to translate, stated she had 17 staples in her stomach from the surgery and confirmed that she had a compression fracture in her back. R160 did not state that she had any pain at the time of the interview, however, did confirm that she has had pain from the surgery and fracture. In an interview on 02/01/24 at 12:48 PM with the DON and UM1, the DON stated, it is our expectation that pain, and communication would be on the baseline care plan. 28306 4. Review of the undated Admission Record under the Profile tab in the EMR revealed R45 was admitted to the facility on [DATE] with the diagnosis of stage four pressure ulcer, cerebral infarction, and hypertension. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R45's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/23/23 coded the resident of having a Brief Interview for Mental Status (BIMS) score of three out of a possible score of 15. This represents R45 was severely cognitively impaired. Review of R45's EMR revealed the resident did not have a base line care plan developed within 48 hours of admission to the facility. R45 was admitted on [DATE]. During an interview on 02/01/24 at 1:11 PM, UM1 reviewed the EMR and stated, There isn't a base line care plan that was started for [R45] . We have a care plan meeting, but it is done when they are here for 72 hours. 5. Review of the undated Admission Record under the Profile tab in the EMR revealed R32 was admitted to the facility on [DATE] with the diagnosis of congestive heart failure, hypertension, and diabetes mellitus. Review of R32's Admission Assessment under the Evaluation tab located in the EMR revealed R32 was alert and oriented. The admission MDS was not completed at that time of the survey. Review of R32's EMR revealed the resident did not have a base line care plan developed within 48 hours of admission to the facility. R32 was admitted on [DATE]. During an interview on 02/01/24 at 10:01 AM, UM2 stated, I only do care plans. I have never heard of giving this to the resident or [responsible party]. How would I know the regulations? We usually have a care plan meeting within 72 hours that we go over this with them. UM2 verbally confirmed R32 did not have a baseline care plan. Review of the facility policy Baseline Care Plan dated 10/02/23 revealed, The facility will develop and implement a baseline care plan for each resident that includes the instructions, needed to provide effective and person-centered care of the resident that meet professional standards of quality care.The baseline care plan will be . developed within 48 hours of a resident's admission . A supervising nurse will verify within 48 hours that a baseline care plan has been developed . A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand . A supervising nurse or MDS [Minimum Data Set] nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative . The person providing the written summary of the baseline care plan shall . Obtain a signature from the resident/representative to verify that the summary was provided . Make a copy for the medical record. If the summary was provided via [by] telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident/representative . NJAC 8:39-11.1 NJAC 8:39-11.2

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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** 28306 Based on observation, staff interview, and record review, the facility staff failed to follow professional standards of practice and left medications at the bedside that were not ordered to be self-administered for one of one resident (Resident (R) 98). Findings include: Review of the undated Admission Record under the Profile tab in the electronic medical record (EMR) revealed R98 was admitted to the facility on [DATE] with the diagnosis of respiratory failure, sepsis, and pneumonia. Review of R98's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/23 coded the resident of having a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15. This represented R98 was cognitively intact. An observation was made on 01/31/24 at 9:38 AM in which Registered Nurse (RN)1 was walking out of R98's room. On the overbed table, there were two pills in a medicine cup left. RN1 returned to R98's room after five minutes and stated, One of those pills is his Lasix [a diuretic] and the other one is his blood pressure medicine. RN1 then stated, I should not have left the room. During an interview on 01/31/24 at 3:00 PM, the Director of Nursing (DON) stated, Nurses are not to leave any medications unattended in the resident's room unless they are self-administrated medications. Review of R98's Physician Orders under the Orders tab located in the EMR revealed orders for Lasix and three blood pressure medications were not ordered to be self-administered. NJAC 8:39-29.2(2)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review, staff interview, and policy review, the facility failed to ensure a safe discharge for residents that left Against Medical Advice by ensuring agencies in the community were made aware the resident was returning to the community prior to a planned discharge and that prescriptions for care and medications were provided to ensure continuity of care for two of two (Resident (R) 107 and R105) residents reviewed for unplanned discharge. Findings include: 1. Review of R107's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, type 2 diabetes, acute kidney failure, hyperkalemia, major depressive disorder, and unspecified psychosis. Review of R107's admission Minimum Data Set (MDS)" assessment, located under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of 10/06/23 revealed she scored 04 out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating severe cognitive impairment. Review of R107's care plan, located under the "Care Plan" tab of the EMR and dated 03/27/19, revealed R107 was care planned for psychotropic drug use, chronic pain, and chronic obstructive pulmonary disease (COPD). Interventions in place were to administer psychotropic medications as ordered and monitor, and oxygen via nasal cannula. Review of R107's "Voluntary Discharge Against Medical Advice," located under the "Observations" tab in the EMR and dated 11/14/23 at 3:25 PM, revealed unit manager (UM) 1 signed the form stating that R107 refused to sign. Review of R107's physician orders, located under the "Orders" tab in the EMR and dated 11/12/23, revealed oxygen inhalation at 3 liter per minute (LPM) to keep oxygen saturation above 92%, Medi honey wound/burn dressing apply to coccyx topically everyday day shift for wound care, hydroxyzine pamoate every 12 hours as needed for anxiety, metoprolol once a day for hypertension, quetiapine fumarate once daily for depression, and midodrine every 8 hours for orthostatic hypotension. Review of R107's "Nurse's Note," located under the "Notes" tab in the EMR and dated 11/13/23 at 4:14 PM, by Licensed Practical Nurse (LPN) 2 revealed R107 left the facility AMA. She was alert and responsive and able to verbalize her needs and was in no distress while leaving the facility. Further review of the EMR Notes tab lacked evidence of discharge planning or discussions of R107's discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/24 at 9:11 AM, LPN2 stated when a resident wanted to leave against medical advice (AMA) staff notified the unit manager and the social worker (SW). LPN2 was unsure if staff were to make these notifications before the resident actually left the building. LPN2 stated staff would speak with the resident and ask them why or what reason led them to want to leave; they should be offered the voluntary discharge form to sign and if they refuse that would have been documented. LPN2 stated the physician should have been notified while the resident was still in the building and the family would have been made aware. LPN2 stated social services along with the physician would have attempted to talk with the resident and make them aware what AMA meant and how it would have affected their medical wellbeing. LPN2 stated if there was any skin care or nebulizer care staff would provide the care before the resident left the building if the resident allowed. LPN2 stated R107's family was here with her, and she signed the AMA form and wound care was also provided prior to R107 leaving but she did not document that. LPN2 stated she made UM1 along with the Social Services Director (SSD) aware and that one of them should have contacted the physician. During an interview on 01/31/24 at 10:20 AM, UM1 stated when a resident requests to leave AMA the team would try to find out why and would notify the physician, family and any other department that was providing care to the resident. UM1 stated staff would have tried to talk to the resident to get them to reconsider and remain in the facility. UM1 stated there was an AMA form that most residents refused to sign but AMA did not happen very often. UM1 stated all notifications should have been documented in the progress notes and if the AMA form was signed or if the resident refused. UM1 stated while R107 was in the facility she refused therapy and was not all there mentally; and R107 would not have been able to leave on her own, someone would have had to come and get her. UM1 stated R107 was always threatening to leave the facility but was unsure if that was ever reported to social services or to anyone else to follow up with the resident. UM1 stated staff should have been proactive and spoke to R107 to see if there was something that could have been done to make her happy with her care prior to her wanting to leave before she was medically ready and that all the notifications should have been documented in progress notes. UM1 confirmed there was no documentation of the notifications. She did not remember anything about R107 leaving AMA. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/24 at 10:40 AM, the SSD stated when a resident left AMA staff would try to discourage them from leaving for their health and wellbeing. The SSD stated they explain what leaving AMA means so the resident can give informed consent and are aware of the possible repercussions of leaving. The SSD stated that was only for a resident with a higher BIMS who would be able to understand the decision, a seven or eight would be too low, and that person would not be considered responsible competent, and staff would have to call next their next of kin. The SSD stated she could have gotten a referral to have a visiting nurse agency (VNA) in the community, but the agency would not accept referrals for residents that left AMA. The SSD stated if the resident's family was on the ball and there was no concern, they may not call adult protective services (APS) because they would not get involved unless there was established neglect and not just if there was a potential for neglect. The SSD stated R107 was a very quiet lady who preferred to lay in bed. The SSD stated R107 had a close relationship with her paramour who visited the facility often. The SSD stated one day R107 decided she wanted to go home. The SSD stated she looked into trying to get her some help and told her she needed an aide in the home to make it a safe discharge. The SSD stated she found an agency that would have provided an aide in the home if R107 signed the form, but she did not have any documentation of that. The SSD stated on the day R107 left AMA she called the resident's son and set up transportation who came and transported R107 home. The SSD stated she did not follow up with R107 in the community after she left, but she thought it was a questionable situation of R107 leaving AMA and was not happy with it. The SSD stated she felt R107 was okay in the community since she had a responsible family who she felt would contact the facility if there were any issues in the community. The SSD stated that all the information should have been documented but she was busy and could not always get to it. During an interview on 01/31/24 at 12:03 PM, R107 stated it was her decision to leave the facility and that her case worker wanted her to sign something to stay at the facility, but she did not have on her glasses and was unable to read the form. R107 stated the facility had a cab or an uber take her home because she did not pay for it. R107 stated she had her house keys and the driver who transported her helped her walk up the 5 stairs in front of her doorway because she went home by herself, and she lived alone. R107 stated none of her family were with her at the facility to escort her home the day she left. R107 stated nobody explained what the form was that she was asked to sign or offered to read it to her. R107 stated she would not sign anything she was unable to read. R107 stated staff did not call her family and did not have to provide her with any prescriptions for any of her medications or supplies for her wound care. During an interview on 01/31/24 at 12:10 PM, Physician 1 said anytime a resident wanted to leave AMA staff should inform her and that most times it was because the resident was unhappy with the facility about their care. Physician 1 could not remember why R107 wanted to leave or what happened and did not remember the specifics of R107 leaving AMA. Physician 1 was unsure if she instructed staff to do anything for R107 or if she spoke with the resident and she would need to look at her records and get back. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up call on 01/31/24 at 12:52 PM, Physician 1 stated she remembered R107 told her she was doing better and was ready for discharge. Physician 1 recalled she told R107 she would talk with therapy and social services to see about setting a discharge date . Physician 1 stated a few days later, 11/13/23 at 3:51 PM, she was told by staff via text that R107 wanted to leave AMA. Physician 1 stated any residents who went AMA who received wound care would have been provided a prescription for the wound care supplies along with a 30 prescription for all regular prescriptions and a 5-day prescription for any narcotic medications and a script for home nursing services. Physician 1 was unsure why that was not provided to R107 and stated she thought R107 just walked out of the facility but stated they can call in the prescriptions to the pharmacy. Physician 1 stated she thought the facility did not have time to provide the scripts to R107 because she thought R107 just walked out. Physician 1 was unable to state why the facility did not ensure R107 was provided with scripts for her medications and wound care supplies. Physician 1 stated again she thought R107 just up and left. When she was informed the AMA was signed as refusing at 3:25 PM but she was not notified by staff until 3:51 PM almost 30 min later, she said she would have expected to be notified timely but would not say if the facility was right or wrong. And again, said R107 was not provided with any scripts for any of her medications, wound care, or a home health nurse. During an interview on 02/01/24 at 1:07 PM, the Director of Nursing (DON) stated when a resident wanted to leave AMA staff would try and encourage the resident to stay and educate them on what leaving against medical advice meant. But if they do decide to leave their physician was notified and an AMA form was filled out and signed. She said the facility did not make anyone in the community aware to ensure they were safe because she said they did not feel the need to notify anyone. She said the residents were educated and it was their choice to leave, and the family was usually aware. 11599 2. Closed record review of R105's Census located in the EMR under the Clinical tab revealed R105 was admitted on [DATE] with diagnoses that included malignant neoplasm of cervix uteri, acute kidney failure, aftercare following surgery for neoplasm, and depression. Review of the Nurses' Progress Notes, dated 12/04/23 at 11:52 AM, located under the Clinical tab in the EMR revealed R105 pt [patient] left with daughter AMA [against medical advice], awake, alert, 0 s/s [zero signs/symptoms] of distress, 0 c/o [zero complaints of] pain, able to make needs known. The progress note was recorded by Licensed Practical Nurse (LPN) 1. Review of the Voluntary Discharge Against Medical Advice form, provided by the facility and dated 12/04/23 at 11:02 AM, revealed R105 signed the form as her own responsible person and LPN1 and UM1 signed the form as witnesses. There was no documentation on the form that the physician had been notified. During an interview on 01/31/24 at 2:40 PM, LPN1 stated she could not remember anything about R105. LPN1 reviewed R105's EMR and stated hospital, she didn't go to the hospital, it says AMA. LPN1 confirmed it was her signature on the progress note dated 12/04/23 at 11:52 AM. LPN1 stated, If someone is going AMA, we have to fill out a form, get a signature, the social worker [SSD] or the unit manager [(UM) 1] call the doctor, I do not. LPN1 stated she did not know if the physician had been notified, there isn't anything documented. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/01/24 at 8:46 AM, UM1 stated she had no recollection of [R105] and no knowledge of who would have called the MD [physician] or if it was done. During a telephone interview on 02/01/24 at 10:51 AM, R105's Physician (Physician 1) stated, I know I have not seen this patient. I don't know that I received a text that she went AMA, but the facility has to document, this is very important. Physician 1 stated she conducts rounding on Tuesdays and Wednesdays. This resident must have left before I saw her. You know they send me information to review medications and give orders. I want to see new patients within 48 hours, but I did not see her, I was not notified she left AMA. During an interview on 02/01/24 at 1:26 PM, with UM1 and the DON, the DON stated, we try to encourage the resident to stay, if they choose to go AMA, then we inform the physician. The UM1 stated, in the interview on 02/01/24 at 1:26 PM, the staff should have the resident sign the form and staff, either me or the SSD call the physician. Review of the facility's policy titled "Discharge Against Medical Advice (AMA)" dated 11/05/23 revealed, the resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present. Notify Adult Protection Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly. NJAC 8:39-35.2(d)15,16

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review, and staff interview, the facility failed to accurately screen residents for elopement risk and have measures in place to ensure residents with a wander guard had documented exit seeking behaviors prior to use for one of one resident (Resident (R)76) reviewed for wander guards. Findings include: Review of R76's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including cerebral infarction, schizophrenia, right bundle branch block, and hemiplegia and hemiparesis. Review of R76's quarterly "Minimum Data Set (MDS)" assessment, located under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of 12/11/23, revealed she scored 09 out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating some cognitive impairment. Further review revealed no wandering behavior exhibited. Review of R76's care plan, located under the "Care Plan" tab of the EMR and dated 03/09/22, revealed "The resident was care planned for risk for elopement related to poor safety awareness Interventions in place were to distract resident from wandering and secure care device. Review of R76's "Elopement Risk Assessment" located under the "Observations" tab in the EMR and dated 12/07/23 revealed R76 was not at risk for elopement. Review of R76's "physician orders" located under the "Orders" tab in the EMR and dated 11/07/23 revealed "check wander guard and placement." Review of R76s "Treatment Administration Record" located under the "Orders" tab dated January 2024 revealed "Nurse to check placement and function every day and evening shift. Further review revealed no expectation to document wandering or exit seeking behaviors. An observation and interview on 01/30/24 at 12:28 PM of R76 revealed lying in bed on top of linens fully dressed along wearing shoes and wander guard on (L) ankle. R76 said the wander guard bothered his leg and he did not know why he had to wear it. He said he has had it on for about 1 year, but staff have never explained to him why he needs to wear it. An observation on 01/31/24 at 8:35 AM R76 walked in hallway from resident room to the TV room. R76 went straight to TV room and did not wander or walk around on the unit or in the hallway. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/24 at 9:31 AM, Certified Nurse Aide (CNA) 1 stated R76 was very independent and provided most of his own activities of daily living (ADL) care. CNA1 stated R76 was nothing by mouth (NPO) and staff did watch him to ensure he did not sneak foods. CNA1 stated R76 was usually out and about in the facility and loved to walk around. R76 did not require any extra supervision for his movement around the facility and has never been exit seeking or attempted to elope. CNA1 knew R76 wore a wander guard, but she was unsure why. CNA1 stated R76 did not ever wander around the facility or walk towards exit doors or in other resident rooms. During an interview on 01/31/24 at 9:36 AM, Licensed Practical Nurse (LPN) 3 stated R76 was not compliant with cares since he was very independent. LPN3 stated sometimes R76 would go to the shower room on his own, but staff were supposed to assist him; R76 spent most of the day sitting in the tv room. LPN3 said he would go back and forth between the tv room and his room throughout the day, but that R76 had never attempted to leave the unit or was exit seeking. LPN3 stated when R76 walked around he knew exactly where he was going, and he went straight there. LPN3 was unsure why R76 wore a wander guard. LPN3 said residents who had to wear wander guards were elopement risks, but R76 was not a risk. During an interview on 02/01/24 at 9:13 AM, Unit Manager (UM) 1 stated residents that were observed trying to exit the facility or expressed a desire to leave would need to wear a wander guard; or if they were observed aimlessly wandering around the facility. UM1 said an elopement risk assessment was completed for all residents on admission, quarterly or as needed. UM1 stated a score of 0 would mean there was no risk for elopement and there would be no need for a wander guard. UM1 said R76 was observed wandering in the facility over a year ago and that when R76 was readmitted from the hospital they discussed the continued need for the wander guard but did not discontinue it. UM1 stated R76 was never one that wanted to go anywhere but he would go into other areas of the facility, but they were areas he was allowed to go. UM1 said there has been ongoing discussion about the continued need for the wander guard but there was no documentation for that. UM1 stated staff do not think he is trying to leave but that they would rather have a wander guard on a resident that does not need it than to miss putting one on a resident that did need it. During an interview on 02/01/24 at 1:27 PM, the Director of Nursing (DON) said all residents that were exiting seeking and ambulatory would have a wander guard placed on them. The DON stated the wander guard was checked on all shifts to ensure they were functioning properly, and staff completed an elopement evaluation quarterly to reevaluate. The DON stated R76 had a wander guard due to a possible history of exit seeking, But he was not exit seeking. When asked why the wander guard was removed yesterday after it was brought to staff's attention, she said they just met as a team and decided he did not need it. But she was unable to state what changed in his behavior or condition day that led to them discontinue the use of a wander guard. A review of the facility's policy titled "Elopement/Missing Residents policy and procedure" updated December 31, 2023, revealed, It is always the policy of the facility to protect residents by identifying and preventing the possibility of elopement and locating residents who are reported missing. Residents who are determined to be an immediate risk for elopement will be placed on wander guard monitoring system when applicable. NJAC 8:39-27.1

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on staff interview and medical record review, the facility staff failed to obtain a physician order when change in treatment occurred and failed to obtain a physician order for wound care when a resident was admitted to the facility for two of five residents (Resident (R) 45 and R32) reviewed for pressure injuries. Findings included: 1. Review of the undated Admission Record under the Profile tab in the electronic medical record (EMR) revealed R45 was admitted to the facility on [DATE] with the diagnoses including stage four (sore extends below subcutaneous fat into deep tissues) pressure injury. Review of R45's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/23/23 coded the resident of having a Brief Interview for Mental Status (BIMS) score of three out of a score of 15. This represents R45 was severely cognitively impaired. Review of R45's Physician Orders, under the Orders tab located in the EMR, revealed the order, Wound vac [vacuum] dressing change every day shift every Mon [Monday], Thu [Thursday] for wound vac, started on 11/23/23 and discontinued on 01/27/24. There were no orders dated for January 2024, at which time the facility was performing dressing changes which had not been ordered. During an interview on 02/01/24 at 9:19 AM, Unit Manager (UM) 2 stated, R45 admitted to the facility with a pressure injury on the sacrum with a wound vacuum. UM2 stated, they had problems with the wound vacuum and stopped using it and started to cover the wound with betadine (antiseptic solution) and covered it. UM2 stated, when she went back to the wound care clinic, we asked if the therapy could be changed because we were having to put our own dressings on it. That visit was a week ago [referring to the last wound care visit on 01/26/24]. UM2 confirmed there was no notification to the doctor and no orders for dressing changes prior to the wound care visit on 01/26/24. On 02/02/24 at 2:10 PM, the Director of Clinical Services was interviewed. The Director of Clinical Services stated, . definitely need an order and notification of the doctor for a change in treatment. 2. Review of the undated Admission Record under the Profile tab in the electronic medical record (EMR) revealed R32 was admitted to the facility on [DATE] with the diagnosis of congestive heart failure, hypertension, and diabetes mellitus. Review of R32's 01/26/24 Admission Assessment under the Evaluation tab located in the EMR, revealed R32 was alert and oriented and was admitted with a stage four pressure injury with eschar (dead tissues) present. The admission Minimum Data Set (MDS) was not completed at that time of the survey. Review of R32's EMR, since admission on 01/26/24, revealed there was no documentation or orders for wound care until 01/30/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/31/24 at 2:23 PM, UM2 stated, The nurse that admitted [R32] should go by the orders that come with the resident or we use Medi-honey on it until the wound care team sees them. The nurse that admitted her was here I think all weekend and she would have been performing the dressing changes. There is a protocol, but I don't know if all the nurses use it. During an interview on 01/31/24 at 3:10 PM, the Director of Nursing (DON) stated, The nurse will assess the wound, we have standing orders for treatment, and confer with the doctor to see if he wants these orders. This should be done on admission for any resident that is found to have a wound. During an interview on 01/31/24 at 3:10 PM, Licensed Practical Nurse (LPN) 4 stated, I used skin prep on it and placed a boot on it [referring to the left ankle wound]. We sprayed skin prep on it each day and covered it with a 4X4 and placed a boot on it .I didn't have a chance to document. I totally forgot; it was so busy with admissions. LPN4 stated the wound treatment was a nursing judgement, she did not recall if she notified the physician of the wound treatment. NJAC 8:39-27.1(e)