| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315290 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Buckingham at Norwood, The | 100 McClellan Street<br>Norwood, NJ 07648 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>38327<br><br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to treat a resident with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of residents' quality of life specifically by not providing a.) breakfast meal in a timely manner for one (1) of nine (9) residents in 2 South dining area and b.) privacy during eye consultation and/or treatment for one (1) of eight (8) residents in 1 South dining area.<br><br>The deficient practice was evidenced by the following:<br><br>1. On 10/31/24 at 8:25 AM, the surveyor observed the breakfast in the 2 South dining room. The surveyor observed nine residents inside the dining room, one Recreation Aide (RA), one Director of Recreation (DoR), and one Quality Assurance Corporate Aide (QACA). The three facility staff were all standing, the DoR and the QACA were talking inside the dining room. Upon entry to the dining room, there was a resident on one table with no breakfast tray seated in a wheelchair, next table were four residents with no breakfast tray, and last table were another four residents with their breakfast trays. At the table where there were breakfast trays, there was one Certified Nursing Aide (CNA) feeding one of the residents. Next to the resident with no breakfast tray, seated on the table by themselves was the food truck with one breakfast tray covered.<br><br>On that same date and time, the surveyor asked the facility employees who was the breakfast tray on the food truck. The QACA checked the breakfast tray, read the diet slip in the tray, and informed the surveyor that the tray was for Resident #25. Resident #25 was the one seated by themselves at one of the tables. The surveyor then asked why Resident #25's breakfast tray was not served to the resident. The CNA responded that she was still feeding the other resident on another table which was why Resident #25 had to wait to be fed. The CNA confirmed that Resident #25 was also a feeder. The QACA then immediately performed hand hygiene with the use of alcohol-based hand rub (ABHR), took Resident #25's tray, sat with the resident, and started feeding the resident.<br><br>At that time, the surveyor asked when the food truck was delivered to the dining room and why the other resident had no breakfast tray. The QACA asked the CNA, and the CNA stated that it was around 8:10 AM that the 1st breakfast truck came. The CNA confirmed that at 8:10 AM residents at one table were served breakfast at that time and that the 2nd breakfast truck would come soon.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On that same date at 8:34 AM, the Registered Nurse/Unit Manager (RN/UM) entered the dining room. The surveyor asked the RN/UM how long the residents should wait for their breakfast tray to be served when they were available. The RN/UM stated that they should immediately provide the resident with their breakfast tray if they were available. The surveyor then notified the RN/UM of the above findings and observations with Resident #25's breakfast tray which was not provided until the surveyor's inquiry.<br><br>On 10/31/24 at 8:40 AM, the surveyor and the RN/UM observed that food truck #2 came and the remaining residents received their breakfast trays in the 2 South dining room. Four out of nine residents received their breakfast trays after 30 minutes while the rest of the five residents had started eating.<br><br>2. On 10/31/24 at 8:49 AM, both the surveyor and the RN/UM went to the 1st-floor dining room in 1 South. The surveyor asked the RN/UM how long the residents should wait for their breakfast tray, when the 1st food truck came at 8:10 AM at 2 South, and was 30 minutes an appropriate time for the residents should wait for their breakfast while other residents were eating in the same room. The RN/UM stated No, the tray should come earlier.<br><br>On that same date and time, inside the 1 South dining room, there were a total of seven residents during breakfast. Two residents were done with their breakfast and the rest were still eating their meals. Resident #67 was seated at one table by themselves and just finished their meal. A person came near Resident #67 and immediately donned (applied) gloves, took a piece of equipment, and was about to use the equipment near the resident's eye. The surveyor asked the RN/UM who was the person with Resident #67. The RN/UM immediately approached the person and addressed the person as a doctor. The RN/UM informed the doctor to remove his gloves and to have the eye consultation in the resident's room.<br><br>Afterward, the surveyor interviewed the RN/UM. The RN/UM stated that the person was the eye doctor. The RN/UM further stated that the doctor should not wear gloves and start treating the resident in the dining room.<br><br>On 11/04/24 at 12:05 PM, the surveyor in the presence of the survey team interviewed the Regional Infection Preventionist Nurse (RIPN) and notified the above findings and concerns. The RIPN stated that the eye doctor should provide privacy during consultation and treatment, and not wear gloves in the dining room.<br><br>On 11/06/24 at 11:19 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Director of Operations (RDO). The surveyor notified the facility management of the above concerns and findings.<br><br>On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, Assistant Administrator (AA), and the RIPN. The RIPN stated that facility staff and the eye doctor were educated.<br><br>A review of the facility's Serving a Meal Policy with a revision date of 11/2023 that was provided by the DON revealed that it is the policy of the facility to serve meals that meet the nutritional needs of residents.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Policy Explanation and Compliance Guidelines: diets should be served in accordance with the physician's order. Residents should be encouraged to eat in the dining room, however, requests to remain in the room should be honored<br><br>A review of the facility's Resident Rights Policy with a revision date of 11/2024 that was provided by the RIPN revealed:<br><br>Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.<br><br>Respect and dignity. The resident has a right to be treated with respect and dignity.<br><br>On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, RDO, Regional Clinical Operations, and AA for the Exit Conference, and there was no additional information provided by the facility management.<br><br>NJAC 8:39 - 4.1(a)11, 12, 16, 28 |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>39399<br><br>Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure reference checks were completed for five (5) out of eight (8) newly hired staff prior to their start date of employment.<br><br>This deficient practice was evidenced by the following:<br><br>The surveyor reviewed eight randomly selected new employee files.<br><br>The review for reference checks for five of the eight new employees revealed the following:<br><br>-Staff #1's file, a Registered Nurse (RN) who was hired on 5/27/24, revealed only 1 reference check in their file.<br><br>-Staff #2's file, a RN who was hired on 9/10/24, revealed only 1 reference check in their file.<br><br>- Staff #3's file, a Certified Nursing Assistant (CNA) who was hired on 10/30/23, revealed no reference checks in their file.<br><br>- Staff #4's file, a CNA, who was hired on 10/16/23, revealed no reference checks in their file.<br><br>- Staff #5's file, a CNA, who was hired on 10/16/23, revealed no reference checks in their file.<br><br>On 11/06/24 at 01:21 PM, the surveyor interviewed the Human Resources Regional Director (HRRD) who stated if the facility was unable to reach the provided reference in the staff's file, they would ask the staff to provide another reference person. The HRRD also stated if the newly hired employee had no work history, they would require a personal reference as part of the background check.<br><br>On 11/07/24 at 11:15 AM, the HRRD confirmed to the surveyor that the 5 newly hired staff did not have a reference background check completed.<br><br>On 11/07/24 at 12:39 PM, the surveyor informed the Licensed Nursing Home Administrator, Director of Nursing, and Infection Preventionist regarding the above concern. There was no additional information provided by the facility.<br><br>The surveyor reviewed the undated facility's policy titled New Hire Process revealed, NOTE: **Some New Hires will be urgent, the below MUST be done in this order and communication MUST be strong, otherwise no credentials will be created**. Further review of the policy revealed under the 3rd step, HR (Human Resources) to complete the below: Once Application and Applicant safe form is cleared: .send reference form.<br><br>N.J.A.C. 8:39-9.3 (a), (b) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>46889<br><br>Based on the interview and record review, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within the 14th calendar day of the resident's admission (admitted plus 13 calendar days) in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for three (3) of 38 residents (Resident #125, #132, and #212) reviewed for resident assessment.<br><br>The deficient practice was evidenced by the following:<br><br>1. On 11/04/24 at 9:50 AM, the surveyor observed Resident #125 lying in bed with eyes open and unable to answer the surveyor's inquiry.<br><br>On 11/04/24 at 11:00 AM, the surveyor reviewed the hybrid (paper and medical) records of Resident #125 and revealed:<br><br>The Admission Record (AR; an admission summary) documented that Resident #125 was admitted to the facility with diagnoses that included but were not limited to encephalopathy (a disease that affects the brain).<br><br>The most recent comprehensive MDS (cMDS) with an Assessment Reference Date (ARD; the last day of the observation period) of 02/04/24, reflected that Resident #125 had a Brief Interview for Mental Status (BIMS) score of 0 (zero) out of 15, indicating severe cognitive impairment. The cMDS was completed on 02/14/24. The assessment was more than 13 days after the entry date on 01/28/24.<br><br>A review of the MDS 3.0 Final Validation Report dated 02/21/24 given by the MDS Coordinator/Registered Nurse (MDSC/RN) on 11/04/24 revealed that The Assessment Completed Late: For this Admission assessment (AO310A equals 01), ZO500B (completion date) was more than 13 days after A1600 (entry date).<br><br>2. On 11/04/24 at 10:27 AM, the surveyor reviewed the medical records of Resident #132 and revealed:<br><br>The AR documented that Resident #132 was admitted to the facility with diagnoses that included but were not limited to unspecified dementia (memory loss), unspecified severity, without behavioral disturbance, psychotic (mental illness) disturbance, mood disturbance, and anxiety.<br><br>Resident #132's most recent cMDS assessment, with an ARD of 5/17/24, reflected that Resident #132 had a BIMS score of 7 out of 15, indicating severely impaired cognition. The cMDS was completed on 5/30/24, more than 13 days after the entry date, 5/10/24.<br><br>A review of the MDS 3.0 Final Validation Report dated 6/10/24 given by the MDSC/RN on 11/04/24 revealed that The Assessment Completed Late: For this Admission assessment (AO310A equals 01), ZO500B (completion date) was more than 13 days after A1600 (entry date).<br><br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. On 11/04/24 at 10:27 AM, the surveyor reviewed the medical records of Resident #212 and revealed:<br><br>The AR documented that Resident #212 was admitted to the facility with diagnoses that included but were not limited to rhabdomyolysis (a condition in which muscle tissue breaks down).<br><br>Resident #212's most recent cMDS assessment, with an ARD of 10/17/24, reflected that Resident #212 had a BIMS score of 8 out of 15, indicating moderate cognition impairment. The cMDS was completed on 11/03/24, more than 13 days after the entry date, 10/10/24.<br><br>A review of the MDS 3.0 Final Validation Report dated 11/4/24 given by the MDSC/RN on 11/04/24 revealed that The Assessment Completed Late: For this Admission assessment (AO310A equals 01), ZO500B (completion date) was more than 13 days after A1600 (entry date).<br><br>On 11/07/24 at 12:57 PM, the surveyor interviewed the MDSC/RN regarding the above concern. The MDSC/RN acknowledged that the admission assessment was not completed on time and should have been completed within 14 days from the entry date. The MDSC/RN stated that the facility followed the RAI (Resident Assessment Instrument) Manual (a tool that helps gather information about a resident's strengths and needs, used to create an individualized care plan).<br><br>According to the CMS's RAI Version 3.0 Manual of October 2024, it was revealed on pages 5-2. CH (chapter) 5: Submission and Correction of the MDS Assessments. 5.2 Timeliness Criteria: In accordance with the requirements long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions: Completion Timing: For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).<br><br>NJAC 8:39-11.2(e) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889<br><br>Based on interview and record review, it was determined that the facility failed to accurately reflect the resident status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with the federal guidelines for two (2) of 38 residents (Resident #125, and #212) reviewed for the accuracy of MDS coding.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 11/04/24 at 9:50 AM, the surveyor observed Resident #125 lying in bed with eyes open and unable to answer the surveyor's inquiry.<br><br>On 11/04/24 at 11:00 AM, the surveyor reviewed the hybrid (paper and medical) records of Resident #125 and revealed:<br><br>The Admission Record (AR; an admission summary) documented that Resident #125 was admitted to the facility with diagnoses that included but were not limited to encephalopathy (a disease that affects the brain).<br><br>Resident #125's most recent comprehensive MDS (cMDS), with an Assessment Reference Date (ARD; the last day of the observation period) of 02/04/24, reflected that Resident #125 had a Brief Interview for Mental Status (BIMS) score of 0 (zero) out of 15, indicating severe cognitive impairment. Section O - Influenza Vaccine, A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? 0. No. C. Influenza vaccine not received, state reason: 5. Not offered. And Pneumococcal Vaccine A. Is the resident's Pneumococcal Vaccination up to date? 0. No. B. If Pneumococcal Vaccine not received, state reason: 1. Not eligible-medical contraindication.<br><br>A review of quarterly MDS (qMDS) dated [DATE] in section O- Influenza Vaccine, A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? 0. No. C. Influenza vaccine not received, state reason: 5. Not offered. And Pneumococcal Vaccine A. Is the resident's Pneumococcal Vaccination up to date? 0. No. B. If Pneumococcal Vaccine not received, state reason: 1. Not eligible-medical contraindication.<br><br>A review of recent qMDS dated [DATE] in section O- Influenza Vaccine, A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? 0. No. C. Influenza vaccine not received, state reason: 5. Not offered. And Pneumococcal Vaccine A. Is the resident's Pneumococcal Vaccination up to date? 0. Yes.<br><br>A review of the Resident Annual Influenza Vaccine Consent Form dated 01/28/24, given by the Regional Infection Preventionist Nurse (RIPN) on 11/07/24, revealed that the resident representative's (RR's) written check off and signature: I do not Consent for the vaccine be given to me or to the person named below for whom I authorized to sign.<br><br>A review of the form titled Pneumococcal Vaccine -Informed Consent dated 01/28/24, given by the RIPN on 11/07/24, revealed that the RR's written check off and signature: I do not Consent for the vaccine be given to me or to the person named below for whom I authorized to sign.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. On 11/04/24 at 10:27 AM, the surveyor reviewed the medical records of Resident #212 and revealed:<br><br>The AR documented that Resident #212 was admitted to the facility with diagnoses that included but were not limited to rhabdomyolysis (a condition in which muscle tissue breaks down).<br><br>Resident #212's most recent cMDS assessment, with an ARD of 10/17/24, reflected that Resident #212 had a BIMS score of 8 out of 15, indicating moderate cognition impairment. Section O - Pneumococcal Vaccine A. Is the resident's Pneumococcal Vaccination up to date? 0. No. B. If Pneumococcal Vaccine not received, state reason: 3. Not offered.<br><br>A review of the form titled Pneumococcal Vaccine -Informed Consent dated 10/11/24, given by the RIPN on 11/07/24, revealed that the RR's with the written check off and signature: I do not Consent for the vaccine to be given to me or to the person named below for whom I authorized to sign.<br><br>On 11/07/24 at 9:20 AM, the surveyor interviewed the RIPN, who acknowledged the incorrect MDS code. She stated that immunizations were offered to all the residents and staff.<br><br>On 11/07/24 at 12:57 PM, the team of surveyors interviewed the MDSC/RN regarding the above concern. The MDSC/RN stated that the vaccine information should be reflected in the MDS assessment. The MDSC/RN stated that the facility followed the RAI (Resident Assessment Instrument) Manual (a tool that helps gather information about a resident's strengths and needs, used to create an individualized care plan).<br><br>According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI Manual of October 2024, the RAI manual was revealed under Version 3.0 Manual, page O-12, under O0250: Influenza Vaccine. Steps for assessment: 1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If the vaccination status is unknown, proceed to the next step. 2. Ask the resident if they received an influenza vaccine outside the facility for this year's influenza vaccination season. If the vaccination status is still unknown, proceed to the next step. 3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step. 4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice. On page O-16, under O0300: Pneumococcal Vaccine. Steps for assessment: 1. Review the resident's medical record to determine whether any pneumococcal vaccines have been received .3. If the resident is unable to answer, ask the same question of the responsible party/legal guardian and/or primary care physician.<br><br>NJAC 8:39-33.2(a) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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>46049<br><br>Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility's interdisciplinary team (IDT) failed to ensure the facility policy was followed to ensure the person-centered care plan was revised to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and to ensure the resident was (invited to participate) involved in the care planning process. The deficient practice was identified for one (1) of 38 residents reviewed for care planning (Resident #131) and was evidenced by the following:<br><br>On 10/29/24 at 10:29 AM, during initial tour, the surveyor observed Resident #131 lying in bed in their room. Resident #131 expressed concern with their discharge (d/c) plans. The resident explained that they had been in the facility for several months, was there to receive rehabilitation (rehab) therapy, and did not have a place to stay outside the facility. Resident #131 stated that they had completed rehab therapy and was independent with activities of daily living. The resident stated when they last spoke with the social worker (SW) about d/c planning, the SW stated something about it was not safe for them to be d/c and did not know anything else about their d/c care plan (CP). The resident stated that they could do more things for their self, compared to other residents, and did not want to stay at facility.<br><br>On 10/30/24 at 11:42 AM, the surveyor reviewed the hybrid (electronic and paper) medical records of Resident #131.<br><br>The Admission Record revealed that Resident #131 had diagnoses that included but were not limited to, Atherosclerotic heart disease (a disease that occurs with the buildup of fats, cholesterol, and other substances in and on the heart's arteries, which may lead to chest pain, shortness of breath and heart attacks), hypertension (high blood pressure), schizophrenia, and type 2 diabetes mellitus (DM). The resident had one emergency contact (EC) listed and they were indicated as the care conference person.<br><br>A Quarterly MDS assessment, dated 8/08/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #131 scored a 13 out of 15, which indicated the resident was cognitively intact.<br><br>A CP for Resident #131 with a focus related to the resident was for LTC (Long Term Care) vs d/c home to community, was initiated 5/06/24. An intervention with an initiation date of 5/06/24 detailed, Resident #131 and their family will make their wishes known.<br><br>A social service (SS) note dated 8/12/24 indicated the IDT met for a quarterly care conference for Resident #131. The EC was invited but did not respond to the facility. There was no documentation of the resident being invited to the CP meeting. Additionally, there was no documentation which indicated the resident was present for the CP meeting or was aware of the discussion from the CP meeting.<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 - Few | A nurse progress note dated 10/01/24, indicated Resident #131 verbalized not wanting to stay in the facility and desired to be d/c. The SW was informed by the nurse that resident stated they did not want to stay in the facility. The nurse further indicated the SW was to follow up with the resident and their status. There were no additional notes from the SW, or any further notes related to the resident's d/c planning.<br><br>On 10/30/24 at 12:41 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to care for Resident #131. The LPN stated the resident was alert and oriented, independent, and cooperative with staff. The LPN stated that the resident did not have a place to stay, and the plan was for the resident to remain in the facility for LTC. The LPN stated the SW was responsible for following up with the resident regarding their living situation.<br><br>On 10/30/24 at 01:03 PM, the surveyor interviewed the SW who started working in the facility a couple of months ago about resident care planning. The SW stated care plan meetings were held quarterly and as needed. The CP meeting was attended by the SW, the Director of Nursing (DON), the dietician, recreation staff, the Director of Rehab, the resident, if they were alert and oriented, and the resident representative. The surveyor asked the SW what the process for care planning for a resident was that did not have a place to live. The SW stated the process would be to attempt to find a next of kin or friend who would be able to assist. If no one could be found, the resident had Medicaid and nowhere else to go then they would be transitioned to LTC.<br><br>The surveyor discussed the concern that Resident #131 expressed they did not want to remain in the facility for LTC and there was no documentation regarding the resident being invited to CP meetings or discussions with the resident about their CP. Additionally, the indicated EC listed had not returned any calls to the facility. The SW confirmed the resident had no place to live and no family or friends involved to help. The SW stated the plan was for the resident to remain for LTC, and discussions with the resident were with Spanish translation. The SW could not speak to referrals or care planning by previous SWs. The SW stated she would review the resident's records and provide additional information.<br><br>On 10/31/24 at 10:31 AM, the SW met with the surveyor. The SW stated she spoke with the resident yesterday evening to discuss possible d/c plans. The SW stated she discussed with the resident about a referral to another LTC facility as a d/c back to the community at this time would be difficult. The resident was agreeable to the referral to the other facility as it would have a similar resident population who spoke their language and they could continue to assist with a possible community d/c. The SW further stated she explained to the resident it may take some time for the d/c to the other facility to be approved.<br><br>The surveyor asked if there were any referrals for the resident during the several months the resident was at the facility. The SW stated there were no referrals as the resident was receiving sub-acute rehab therapy. The SW further stated upon admission the resident signed a LTC agreement which indicated the resident would be transitioned to LTC.<br><br>The surveyor asked if there was any documentation of the resident being invited or participating in their CP meetings. The SW provided hospital d/c notes for the resident and the LTC admission agreement signed by the resident, which was handled by the Admissions department. The SW stated she would provide the SS documentation for Resident #131.<br><br>(continued on next page) |

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|---|---|---|---|
| | 315290 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Buckingham at Norwood, The | 100 McClellan Street<br>Norwood, NJ 07648 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the hospital d/c notes for Resident #131 indicated the resident did not have a place to live and would be d/c to the facility from the hospital for SAR [Subacute Rehab].<br><br>On 10/31/24 at 11:23 AM, the SW provided SS documentation which included, a SS note written by the SW dated 10/30/24 regarding her discussion with the resident about the referral to another facility. Additionally, there was the SS note by the previous SW on 8/12/24, and a BIMS evaluation by another previous SW, dated 5/3/24. There was no additional documentation provided.<br><br>On 10/31/24 at 12:50 PM, the surveyor visited Resident #131 in their room who confirmed that the SW spoke with them yesterday. The resident stated they were agreeable with being transferred to another facility as there was a different resident population. The resident verbalized they understood it would still be a LTC facility, and that they would continue to assist with d/c to the community. Resident #131 further explained they understood it may take time. The resident was satisfied and agreeable to the CP.<br><br>On 11/06/24 at 11:19 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Operations (RDO) of the concern for Resident #131 not being invited to participate in their care planning. There was no verbal response from the facility at this time.<br><br>On 11/07/24 at 11:31 AM, the DON, LNHA, and a regional LNHA, met with the survey team. The DON stated Resident #131 did not have a place to stay when they arrived at facility and had not previously expressed not wanting to be at facility. The DON continued that the SW went to the resident, was referred to other facility and had since been d/c. The surveyor asked the DON about SW documentation when care plan meeting with residents. The DON stated that the SW was responsible for initiating CP meetings and would invite residents/resident representatives to participate in the meeting. The DON acknowledged it should be documented in the resident's medical records when a resident was invited to CP meetings and participated in CP discussions with the SW. There was no additional information provided by the facility.<br><br>The surveyor reviewed the facility's policy titled, Discharge Planning Process Policy, with a last review date of November 2024. Under Policy Explanation and Compliance Guidelines it documented: .<br><br>1. The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for d/c .<br><br>3. If d/c to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why .<br><br>8. The facility will document any referrals to local contact agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community .<br><br>11. The evaluation of the resident's d/c needs and d/c plan will be completely documented on a timely basis in the clinical record .<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 - Few | The surveyor reviewed the facility's policy titled, Comprehensive Care Plans, with a last review date of September 2024. Under Policy Explanation and Compliance Guidelines it documented: .4. The comprehensive CP will be prepared by an IDT team, that includes, but not limited to .e. The resident and the resident's representative, to the extent practicable .<br><br>The surveyor reviewed the facility's policy titled, Resident Rights, with a last review date of November 2024. Under Residents Rights Acknowledgement, Planning and implementing care, it documented: .The resident has the right to be informed of, and participate in, his or her treatment including .b. the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to . the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care .<br><br>NJAC 8:39-4.1(a); 27.1(a) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>46049<br><br>Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to a.) follow the physician orders with regard to medications (meds) with parameters for five (5) of five (5) residents (Residents #28, #117, #131, #140, and #142) and b.) ensuring meds administered to a resident were not left at the bedside for one (1) of 38 residents (Resident #144 ), according to the standard of clinical practice.<br><br>This deficient practice was evidenced by the following:<br><br>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 and potential physical and emotional health problems, through such services as case-finding, 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.<br><br>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 case finding; 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.<br><br>1. On 10/31/24 at 9:45 AM, the surveyor reviewed the hybrid (electronic and paper) medical records of Resident #28.<br><br>The Admission Record (AR; admission summary) revealed that Resident #28 had diagnoses that included but were not limited to, End stage renal [Kidney] disease, hyperlipidemia (high levels of fats in the blood), and atherosclerotic heart disease (a disease that occurs with the buildup of fats, cholesterol and other substances in and on the heart's arteries, which may lead to chest pain, shortness of breath and heart attacks).<br><br>A quarterly Minimum Data Set (qMDS) an assessment tool used to facilitate management of care, with an Assessment Reference Date (ARD) of 9/22/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #28 scored a 12 out of 15, which indicated the resident had moderate cognitive impairment.<br><br>A physician's order (PO) dated 9/28/24 documented hydralazine oral tablet (tab) 50 mg (milligram), give 1(one) tab by mouth two times a day every Monday, Wednesday, Friday, and Sunday for hypertension (high blood pressure) Hold if BP < 140 [Blood Pressure less than 140]. The medication (med) was scheduled to be administered at 9:00 AM (9 AM) and 5:00 PM (5 PM).<br><br>A PO dated 9/28/24 documented hydralazine oral tab 50 mg, give 1 (one) tab by mouth two times a day every Tuesday, Thursday, and Saturday for hypertension Hold if BP < 140. The med was scheduled to be administered at 5:00 AM (5 AM) and 5 PM.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the October 2024 electronic Medication Administration Record (eMAR) revealed the nurses signed the hydralazine med as administered on 10/07/24 at 9 AM and 5 PM, 10/13/24 at 9 AM and 5 PM, and 10/27/24 at 9 AM. For these identified entries the BP was documented to be less than 140 and the hydralazine medication should have been held per the PO.<br><br>On 10/31/24 at 10:19 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) about the administration of meds with parameters. LPN #1 stated the vital signs, such as BP, would be checked first and the med's parameters should be followed as ordered by the physician. The surveyor reviewed with LPN #1 the hydralazine order entries in the October 2024 eMAR and the identified entries for the med administered outside of the orders' parameters. LPN #1 stated the med should not have been given as the med should have held per PO.<br><br>On 10/31/24 at 01:13 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) about the administration of meds with parameters. RN/UM stated if a med's parameters related to BP, the nurse would check the BP prior to administering the med and would hold the med according to the PO. RN/UM further explained it was expected that the nurses followed the PO. The surveyor reviewed with the RN/UM the identified hydralazine entries that were administered outside of the order parameters on the October 2024 eMAR. The RN/UM acknowledged the med should have been held by nurses according to the PO.<br><br>2. On 11/06/24 at 9:03 AM, the surveyor reviewed the hybrid medical records of Resident #131.<br><br>The AR revealed that Resident #131 had diagnoses that included but were not limited to, Atherosclerotic heart disease, hypertension (high blood pressure), and type 2 diabetes mellitus (DM).<br><br>A qMDS with an ARD of 8/08/24, indicated the facility assessed the resident's cognition using a BIMS test. Resident #131 scored a 13 out of 15, which indicated the resident was cognitively intact.<br><br>A PO dated 9/10/24 documented Humalog Kwik pen subcutaneous solution pen-injector 100 Units/milliliters (Units/ml), inject 3 units subcutaneously before meals for DM three times a day before meals. Hold for glucose (blood sugar) below 110. The med was scheduled to be administered at 7:30 AM, 11:30 AM and 4:30 PM.<br><br>A review of the October 2024 eMAR revealed the nurses signed the Humalog medication as administered when the blood sugar (BS) was less than 110 on the following entries:<br><br>-On 10/02/24 at 4:30 PM with a documented BS of 87.<br><br>-On 10/05/24 at 7:30 AM with a documented BS of 103.<br><br>-On 10/14/24 at 7:30 AM with a documented BS of 95.<br><br>-On 10/15/24 at 7:30 AM with a documented BS of 85.<br><br>-On 10/17/24 at 11:30 AM with a documented BS of 103.<br><br>-On 10/27/24 at 11:30 AM with a documented BS of 84.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/06/24 at 9:40 AM, the surveyor reviewed with the RN/UM the humalog entry on the October 2024 eMAR of Resident #131. The RN/UM acknowledged the PO were not being followed and stated when the BS was less than 110 the med should have been held.<br><br>On 11/06/24 at 11:19 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Regional Director of Operations (RDO) of the concerns that the PO for the identified meds with parameters for Resident #28 and Resident #131 were not being followed. The DON acknowledged it was expected for the nurses to follow the PO.<br><br>On 11/07/24 at 11:31 AM, the LNHA, the DON, and a regional LNHA met with the survey team. The DON stated the nurses received disciplinary action and education on the importance of following med parameters as ordered by the physician. There was no additional information provided by the facility.<br><br>48423<br><br>3. On 10/30/24 at 12:23 PM, the surveyor observed Resident #117 eating lunch in the dining room.<br><br>The surveyor reviewed Resident #117's hybrid medical records that revealed the following:<br><br>The AR reflected that the resident was admitted to the facility with diagnoses that included Dementia, depression, hypertension, and DM.<br><br>The qMDS with an ARD of 9/15/24, reflected that Resident #117 had a BIMS score of 00 out of 15, which indicated that the resident's cognition was severely impaired.<br><br>A review of the Order Summary Report (OSR) reflected that Resident #117 had an active PO dated 9/21/24 for a med: Midodrine HCL (hydrocholoride) Oral Tab 5 mg- Give 1 tab by mouth three times a day for low BP HOLD for SBP [systolic BP] greater than 140 with a start date of 9/22/24.<br><br>The corresponding PO was transcribed into the September 2024 through November 2024 eMAR. Further review of the September - November 2024 eMARs for Resident #117 revealed that nurses signed and reflected a checkmark which means that the med was administered when the med should have been held for a SBP that was greater than 140 according to the PO, for the following dates and times:<br><br>Date Time SBP<br><br>9/22 9 AM 145/76<br><br>9/24 1:00 PM (1 PM) 153/85<br><br>10/2 5 PM 146/84<br><br>10/10 5 PM 146/84<br><br>10/12 5 PM 146/78<br><br>10/18 5 PM 145/84<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10/29 5 PM 145/84<br><br>11/1 5 PM 146/84<br><br>During an interview with the surveyor on 11/06/24 at 10:06 AM, Registered Nurse #1 (RN#1) stated that the Midodrine was for hypotension (for low BP) and if the BP was higher than 140, then we would not give the med. RN#1 further stated that after 30 minutes, she would re-check BP and if the BP was high (greater than 140) then she would hold the med and notify the physician.<br><br>During an interview with the surveyor on 11/06/24 at 10:14 AM, Licensed Practical Nurse/Unit Manager (LPN/UM) stated that we would hold the med if SBP was outside the parameters and notify the doctor. The LPN/UM further stated if the med was given for SBP > 140 (greater than 140), then she would notify the physician and DON. The surveyor informed the LPN/UM of the above concerns. The LPN/UM acknowledged that it was considered a med error.<br><br>On 11/06/24 at 11:19 AM, the surveyor discussed the above concerns with the LNHA, DON and RDO of the above concerns. The DON stated that the expectation from the nurses was to follow the protocol and the med should have held when the SBP was outside the parameters.<br><br>A review of the facility provided Job Descriptions for Position Title: Registered Nurse and Licensed Practical Nurse reflected under Responsibilities/Accountabilities: *Dispenses med and performs treatments, as requested, and in accordance with policies and procedures; * Adhere to all facility policies and procedures.<br><br>On 11/07/24 at 11:32 AM, the survey team met with the LNHA, DON, Regional Infection Preventionist Nurse (RIPN), and Regional Administrator. The DON stated that the nurses should check and follow the parameters before administering the BP meds. The DON acknowledged that it was a med error.<br><br>On 11/07/24 at 01:30 PM, the survey team met with LNHA, DON, RIPN, RDO, Regional Administrator for an exit conference. The facility did not refute the findings.<br><br>38327<br><br>4. On 10/29/24 at 10:21 AM, the surveyor observed posted signs outside Resident # 140's room for oxygen (O2) in use, EBP (enhanced barrier precautions), and PPE (personal protective equipment) box hung outside the door. The resident was lying in bed with a nasal cannula (a device that delivers extra O2 through a tube and into the nose) and O2 at 2LPM (liters per minute) attached to the concentrator (a device for O2).<br><br>The surveyor reviewed the hybrid medical records of Resident #140.<br><br>The AR revealed that the resident was admitted to the facility that included a medical diagnosis that was not limited to essential hypertension (high blood pressure that is not due to another medical condition), chronic kidney disease, and DM.<br><br>According to the comprehensive Minimum Data Set (cMDS) with an ARD of 10/12/24, Section C Cognitive Patterns revealed a BIMS score of 11 out of 15 which reflected that the resident's cognitive status was moderately impaired.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the PO with an order date of 10/23/24 for Midodrine HCl oral tab 5 mg give 1 tab via G-Tube (gastrostomy tube) three times a day for hypotension Hold if SBP>120 (systolic blood pressure less than 120) mmHg (millimeter of mercury)<br><br>The above orders for Midodrine were transcribed to the October 2024 eMAR. There were five events that the med was administered beyond the parameters and did not follow the PO as shown below:<br><br>Date Time Blood Pressure<br><br>10/26/24 9 AM 129/75 (SBP 129)<br><br>10/26/24 1 PM 128/72 (SBP 128)<br><br>10/26/24 5 PM 127/78 (SBP 127)<br><br>10/27/24 9 AM 126/72 (SBP 126)<br><br>10/27/24 1 PM 126/72 (SBP 126)<br><br>On 10/31/24 at 9:08 AM, the surveyor notified LPN#2 of the above findings and concerns with the Midodrine. The LPN stated that the PO for Midodrine parameters not to administer the med if the SBP was above 120 should be followed.<br><br>5. On 10/29/24 at 10:31 AM, the surveyor observed a posted sign for EBP and PPE hung outside the door. Inside the resident's room, Resident #142 was in bed asleep.<br><br>The surveyor reviewed the medical records of Resident #142.<br><br>The AR showed that the resident was admitted to the facility that included a medical diagnosis that was not limited to essential hypertension, unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and DM.<br><br>The cMDS with an ARD of 8/12/24, Section C Cognitive Skills for Daily Decision Making was coded #2 which reflected that the resident's cognition was moderately impaired.<br><br>A review of the PO order date 10/04/24 for Amlodipine Besylate Oral Tab 10 mg Give 1 tab by mouth one time a day for HTN (hypertension) Hold if SYS<110 OR HR<60 (systolic less than 110 or heart rate less than 60)<br><br>The above order for Amlodipine was transcribed to October 2024 eMAR. There were four events in the med was administered beyond the parameters and did not follow the PO as shown below:<br><br>Date Time Blood Pressure HR<br><br>10/17/24 9 AM 119/71 56<br><br>10/20/24 9 AM 121/66 58<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10/23/24 9 AM 113/70 59<br><br>10/25/24 9 AM 115/68 59<br><br>Further review of the October 2024 eMAR showed an order date of 10/04/24 for Losartan Potassium Oral Tab 100 mg Give 1 tab by mouth one time a day for HTN Hold if SYS<110 OR HR<60.<br><br>The above order for Losartan was transcribed to October 2024 eMAR. There were four events in the med was administered beyond the parameters and did not follow the PO as shown below:<br><br>Date Time Blood Pressure HR<br><br>10/17/24 9 AM 119/71 56<br><br>10/20/24 9 AM 121/66 58<br><br>10/23/24 9 AM 113/70 59<br><br>10/25/24 9 AM 115/68 59<br><br>On 10/31/24 at 9:08 AM, the surveyor notified LPN#2 of the above findings and concerns with the Amlodipine and Losartan. The LPN stated that the PO for Amlodipine and Losartan parameters not to administer the meds if the SBP was above 110 and HR below 60 should be followed. The LPN acknowledged that he was the nurse who signed the eMAR on 10/17, 10/20, 10/23, and 10/25/24 at 9 AM.<br><br>On 11/06/24 at 11:19 AM, the survey team met with the LNHA, DON, and RDO. The surveyor notified the facility management of the above concerns and findings.<br><br>On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, Assistant Administrator (AA), and RIPN. The DON stated that the PO for parameters should have been followed by nurses.<br><br>51226<br><br>6. On 10/29/24 at 10:25 AM, the surveyor observed Resident #144 lying in bed, awake, alert and not verbally responsive to surveyor's greeting. The surveyor observed a med cup filled with a mixture of meds and apple sauce on the overbed table. The Resident's Representative (RR) stated that they were the one who would give the meds to the resident.<br><br>On 10/29/24 at 10:30 AM, the surveyor interviewed LPN #3 who was assigned to care for Resident #144. The LPN acknowledged that he left the meds for 9 AM scheduled meds mixed in the cup with applesauce on the Resident's overbed table. The LPN stated that the RR would give the meds to the resident. The surveyor asked what meds were on the cup. The LPN showed the surveyor the eMAR which included the following meds that were in the cup: Lexapro 10 mg (antidepressant), Acetaminophen 500 mg 2 tabs (pain med) and Memantine 10 mg (med for Dementia). The surveyor and LPN#3 went to the resident's room. The surveyor observed the RR administered the meds in the cup with applesauce to the resident under the supervision of the LPN after surveyor's inquiry.<br><br>(continued on next page) |

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| | 315290 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Buckingham at Norwood, The | 100 McClellan Street<br>Norwood, NJ 07648 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/29/24 at 10:40 AM, the surveyor interviewed the RN/UM about med administration protocols. The surveyor notified the RN/UM of the above observation of meds left at the bedside of Resident #144. The RN/UM stated a RR needed to be assessed for the capability of administering meds to a resident and it should be care planned. The RN/UM further stated meds must be given an hour or an hour after the med was scheduled to be given. The surveyor and the RN/UM went to speak with LPN #3. The LPN confirmed to the RN/UM that the med was left at the bedside. The RN/UM educated LPN #3 about not leaving meds at bedside and ensuring meds were administered timely as per PO.<br><br>On 11/04/24 at 11:05 AM, the surveyor reviewed the hybrid medical records of Resident #144.<br><br>The AR revealed that Resident #144 was admitted to the facility and had diagnoses that included but were not limited to, atrial fibrillation and dementia (condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning).<br><br>The cMDS with an ARD of 9/14/24 revealed the facility assessed the resident's cognition using a BIMS test. Resident #144 scored a 99, which indicated the resident was unable to complete the interview.<br><br>The OSR included a PO dated 10/29/24 which indicated, may combine all crushable meds (according to manufacturer's guidelines) at one time mixed in (applesauce, pudding, etc.) every shift.<br><br>A care plan (CP), initiated on 10/29/24 revealed that Resident #144's RR preferred to give meds after meals. There was no documented evidence that resident had a CP that the RR will administer meds.<br><br>On 11/06/24 at 11:30 AM, the surveyor notified the DON, the LNHA, and RDO about the above concerns.<br><br>On 11/07/24 at 11:50 AM, the DON, LNHA, and RIPN met with the survey team. The DON stated that family was educated not to give meds and that in-service education was conducted regarding med administration.<br><br>A review of the facility's Medication Administration Policy with a revision date of 9/2023 that was provided by the RIPN revealed:<br><br>Policy: Meds are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.<br><br>Policy Explanation and Compliance Guidelines:<br><br>8. Obtain and record vital signs, when applicable or per PO. When applicable, hold med for those vital signs outside the physician's prescribed parameters .<br><br>10. Review MAR to identify med to be administered .<br><br>15. Observe resident consumption of med .<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, RDO, Regional Clinical Operations, and AA for the Exit Conference, and facility management did not provide any additional information and did not refute the findings.<br><br>NJAC 8:39-11.2(b), 27.1 (a), 29.2(d) |

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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** 46049<br><br>Complaint # NJ167164 and #167919<br><br>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and facility policies and procedures for one (1) of 38 residents, Resident #360, reviewed for quality of care.<br><br>This deficient practice was evidenced by the following:<br><br>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 and potential physical and emotional health problems, through such services as case-finding, 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.<br><br>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 case finding; 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.<br><br>On 10/31/24 at 12:44 PM, the surveyor reviewed a facility reported event investigation for Resident #360 who was no longer a resident at the facility.<br><br>A report dated 9/01/23 was submitted to the Department of Health (DOH) for an event that occurred on 8/30/23. The Resident's representative (RR) reported to the facility regarding the care of Resident #360 and wounds found on the resident's right foot.<br><br>The investigation included written statements from nursing staff, a summary and conclusion as well as in-service education provided to the Licensed Practical Nurse (LPN).<br><br>The summary of the facility's investigation detailed Resident #360 was found on 8/29/23 with ulcers to the dorsum [top of] right foot, near the right toes, the right 5th toe, and sole of the right foot. The wounds were noted with serosanguineous (contains both blood and serum, the liquid part of blood) drainage. The nurse practitioner (NP) examined the resident the same day. The NP ordered x-rays of the foot, intravenous (IV) antibiotics, a wound consult, podiatry consult, and infectious disease (ID) consult. The physician then called and gave the order for Resident #360 to be sent to the hospital emergency room (ER) for further evaluation. The RR was also notified. The resident was admitted to the hospital after ER evaluation with a diagnosis of osteomyelitis (an inflammation of bone caused by an infection). The resident returned to the facility on [DATE].<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 | The conclusion of the facility's investigation determined that weekly skin checks had not been completed for two weeks prior to the wounds' identification. Additionally, nursing management were to conduct weekly audits to ensure that weekly skin checks would being completed on time and accurately documented.<br><br>The education in-service provided to the LPN included review of the importance of completing weekly skin checks, poor outcomes of a resident's condition if skin checks were not completed, and the importance of reporting any new findings including communication with the physician and RR.<br><br>The surveyor reviewed the paper and electronic medical record (EMR) of Resident #360.<br><br>The Admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, quadriplegia (a condition that causes a person to lose all or most motor function in their arms, hands, trunk, legs and pelvic organs), major depressive disorder, contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of muscle/joint, peripheral vascular disease (PVD; a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), neuromuscular dysfunction of bladder (a condition that causes bladder control issues due to a brain, spinal cord or nerve problem), and hypertension.<br><br>A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 6/20/23, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #360 scored a 14 out of 15, which indicated the resident was cognitively intact. In Section G (Functional Status) of the MDS, Resident #360 was coded requiring one person assist with activities of daily living (ADLs) such as bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. The resident was coded as: dependent on staff for bed mobility and toilet use; needing extensive assistance with personal hygiene and dressing; and limited assistance for eating. Additionally, Resident #360 was coded for impairment in range of motion to both lower extremities.<br><br>A physician's order (PO) dated 01/06/22 documented bunny boots heel protector/apply to both heels while in bed every shift for protection.<br><br>A PO dated 01/06/22 documented offload heels with one pillow under calves while in bed every shift for skin integrity.<br><br>A PO dated 3/16/23 documented to apply moisturizer cream to the resident's legs everyday every day shift for skin care/dryness.<br><br>A PO dated 1/6/22 documented skin assessment weekly every Wednesday on 7-3 shift every day shift for monitoring.<br><br>A review of the Evaluation section of the EMR revealed there was one Skin Evaluation documentation completed on 8/02/23 for August 2023. There was no other skin evaluation completed for the month.<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 | A physician progress note (PN) dated 8/29/24 at 1:00 PM by the NP detailed then nurse reported the resident had a wound to their right foot and the resident was assessed. After initial plan of orders for treatment including x-rays, IV antibiotics, and consults, the primary physician ordered for the physician to be sent to the ER for further evaluation.<br><br>A nurses' PN written by the LPN dated 8/29/24 at 02:26 PM, revealed the resident was found with a wound to the right foot, it was cleaned with normal saline solution and reported to the primary physician. The primary physician ordered for the resident to be transferred to the hospital ER for further evaluation and the resident was transferred at 2:00 PM.<br><br>A review of August 2023 PN revealed there were no notes prior to August 29th regarding the resident's skin assessment or refusal by the resident to complete.<br><br>A care plan with an initiation date of 6/11/2020 had a focus of risk for impaired skin integrity related to the resident's immobility, PVD, history of pressure ulcers, and refusal of care. Interventions of the care plan included but were not limited to: Perform routine skin assessments, date initiated 6/11/2020; and Provide skin care per facility guidelines and PRN (as needed), date initiated 6/11/2020.<br><br>On 11/06/24 at 9:55 AM, the surveyor interviewed the LPN who had cared for the resident and signed the weekly skin assessments in August 2023. The LPN recalled Resident #360 and stated the resident was alert and wheelchair bound. The resident was out of bed on Monday through Thursday and from Friday to Sunday preferred to stay in bed watching television. The LPN stated Resident #360 was cooperative with care for the most part but refused care occasionally. The LPN further explained the resident hands and feet were a little contracted and allowed staff to assess them. The surveyor asked about assessing the resident's skin. The LPN replied that the Certified Nurse Assistant (CNA) would provide morning care to resident and notified the nurses of any skin impairment. The nurses performed weekly skin assessments, checking head to toe and documented in the EMR of the findings.<br><br>The surveyor asked about when the resident was found with wounds and had to be sent to the hospital. The LPN recalled the resident was found with a wound to their foot that was oozing prior to being sent to the hospital. The LPN could not recall specific dates or times and stated he found the resident's sock was sticky, removed their sock, found wounds to their toes, and reported to the NP who was visiting. The LPN could not recall any additional details.<br><br>On 11/06/24 at 10:27 AM, the surveyor interviewed the Director of Nursing (DON) about Resident #360's investigation. The DON confirmed that the incident occurred prior to her and the current Licensed Nursing Home Administrator (LNHA) starting at the facility. The surveyor asked about any additional information related to the investigation. The DON stated she would review what was on file and could not speak to the investigation that was conducted by the previous administration.<br><br>On 11/06/24 at 11:19 AM, the surveyor notified the LNHA, the DON, and the Regional Director of Operations (RDO) of the concern that there were no skin evaluations documented for the two weeks prior to the wounds to the resident's foot was identified by the staff. There was no verbal response by the facility at this time.<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 | On 11/07/24 at 11:31 AM, the DON, the LNHA, and the regional LNHA met with the survey team. There was no additional information or verbal response provided by the facility. The DON stated they could not speak to specifics as it was during the previous administration's time.<br><br>The surveyor reviewed the undated facility policy titled Skin Check Policy. Under Procedure it specified, . 2. Skin checks will be conducted by CNA's during daily care .3. Skin checks by Licensed Nurses will be conducted weekly on all residents in addition to daily checks by CNA's .4. Findings will be documented in the Weekly Skin Evaluation form and the Interdisciplinary Notes .<br><br>N.J.A.C. 8:39-3.2 (a), (b); 27.1 (a) |

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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** 38327<br><br>Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen and nebulizer, according to the standard of clinical practice and the facility's policy and procedure, specifically a.) that respiratory equipment was stored in accordance with facility policy and infection control measures for two (2) of two (2) residents reviewed for respiratory care, Resident #210 and #213, b.) clarify the oxygen therapy order and ensure staff followed the appropriate hand hygiene and use of personal protective equipment (PPE) for a resident with contact precautions and oxygen posted sign for one (1) of one (1) of resident, Resident #213, reviewed for tracheostomy care.<br><br>This deficient practice was evidenced by the following:<br><br>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 and potential physical and emotional health problems, through such services as case-finding, 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.<br><br>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 case finding; 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.<br><br>1. On 10/29/24 at 10:35 AM, the surveyor observed Resident #210 inside their room seated in a wheelchair. The resident was cognitively intact and informed the surveyor that they were at the facility for rehabilitation. The surveyor observed the nebulizer (neb) mask was not properly stored and was placed on top of the nightstand table near the window next to the neb machine. The date of the neb mask was 10/28/24.<br><br>At that time, the resident informed the surveyor that the nurse administered neb to the resident and confirmed the neb mask on top of the nightstand was not properly stored and should have been inside a bag.<br><br>The surveyor reviewed the medical records of Resident #210 and revealed:<br><br>The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to other asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe), unspecified diastolic (congestive) heart failure, and essential (primary) hypertension (occurs when abnormally high blood pressure that's not the result of a medical condition).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The most recent comprehensive Minimum Data Set (cMDS) with an assessment reference date (ARD) of 10/04/24, under Section C Cognitive Patterns, reflected on a brief interview for mental status (BIMS) score of 15 out of 15 which showed that the resident was cognitively intact. The cMDS also included that the resident received respiratory therapy for 225 minutes in a seven-day look-back period (the time period over which the resident's condition or status was captured by the MDS assessment).<br><br>A review of the October 2024 Order Summary Report (OSR) revealed a physician's order (PO) for the following:<br><br>-order date 10/01/24 for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (3 milligrams/3 milliliters) 3 ml inhale orally every 6 hours for wheeze.<br><br>-order date 9/28/24 to Change neb administration set up (tubing, nasal cannula/mask, etc) weekly one time a day every Mon (Monday).<br><br>The above order for Ipratropium-Albuterol inhalation was transcribed and plotted to the October 2024 electronic Medication Administration Record (eMAR) and signed by nurses as administered at 0000 (12 midnight), 0600 (6 AM), 1200 (12 noon), and 1800 (6 PM).<br><br>On 10/31/24 at 9:07 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN informed the surveyor that the neb mask should be stored in a plastic bag when not in use. The surveyor then notified the LPN of the above concern with the resident's neb mask observed on 10/29/24 which was not properly stored.<br><br>2. On 10/29/24 at 10:17 AM, the surveyor interviewed the LPN in the Penthouse unit. The LPN informed the surveyor that there was no resident on contact precaution (intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment). The LPN stated that there were residents on EBP (Enhanced Barrier Precautions), residents who had tube feeding (TF), wounds, and tracheostomy (a procedure to help air and oxygen (O2) reach the lungs by creating an opening into the trachea (windpipe) from outside the neck). He further stated that the Staff and visitors must wear PPE, i.e. gown, gloves, and mask (when tracheostomy or splashes) when providing direct care like wound care morning care, and toileting for EBP residents. The LPN stated that Resident #213 was on EBP due to TF and tracheostomy (trach).<br><br>On 10/29/24 at 10:26 AM, the surveyor observed Resident # 213's room with a Stop sign, Contact Precaution sign, PPE hung outside the door, and O2 in use sign. The surveyor observed the resident was lying on the bed. The Recreation Aide (RA) was inside the room without PPE, exited the resident's room, and did not perform hand hygiene. The posted Contact precaution sign included information that whoever enters and exits the room must perform hand hygiene, and enter with a gown, gloves, and mask.<br><br>On 10/29/24 at 10:30 AM, the surveyor asked LPN again if Resident #213 was on contact precaution and what kind of infection. The surveyor also notified the LPN of the above concerns that there was a posted sign for contact precautions outside the door of the resident. The LPN stated that he would get back to the surveyor and verify the records.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/29/24 at 10:42 AM, the surveyor interviewed the LPN and asked again about the resident's posted contact precaution sign and the LPN confirmed the resident on contact precaution for positive MRSA (Methicillin-resistant Staphylococcus aureus is a group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus aureus. MRSA is responsible for several difficult-to-treat infections in humans) in the trach and nares. He stated that staff and visitors must use complete PPE that included mask, gown, and gloves when entering the room and perform hand hygiene.<br><br>At that time, the surveyor notified the LPN of the concern regarding the RA. The LPN immediately called the RA and education was provided. The RA confirmed that she did not put on PPE before entering the resident's room and informed the LPN that she did not touch anything when she entered the room. The LPN told the RA that she had to read the posted sign and that meant she had to do hand hygiene before entering put on PPE, remove PPE before exiting, and perform again hand hygiene.<br><br>On 10/29/24 at 11:02 AM, the surveyor met with LNHA in the presence of two other surveyors, the Assistant Administrator (AA), and a Registered Nurse/Unit Manager (RN/UM). The LNHA and the RN/UM informed the surveyor that there were transmission-based precautions (TBP; Transmission-based precautions are used when patients already have confirmed or suspected infections) other than COVID which was one resident with MRSA in the Penthouse unit.<br><br>The surveyor reviewed the medical records of Resident #213 and showed:<br><br>The AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to nontraumatic intracerebral hemorrhage (a common subtype of stroke with a poor prognosis, high mortality, and long-term morbidity) unspecified, chronic respiratory failure (a condition that occurs when the lungs cannot get enough O2 into the blood or eliminate enough carbon dioxide from the body) unspecified with hypoxia (an absence of enough O2 in the tissues to sustain bodily functions) or hypercapnia (a buildup of carbon dioxide in bloodstream), and tracheostomy status.<br><br>The most recent cMDS with an ARD of 10/28/24, under Section C BIMS score of 00 out of 15 showed that the resident's cognition was severely impaired. The cMDS also included that the resident received respiratory therapy for 375 minutes in a seven-day look-back period.<br><br>A review of the personalized care plan (CP) showed a focus CP for MRSA in trach that was created on 10/22/2024. The CP interventions included but were not limited to contact isolation, educate resident/family/caregivers regarding the importance of hand washing, and instruct family/visitors/caregivers to wear disposable gowns and gloves during physical prolonged contact with the resident, and discard in the appropriate receptacle and wash hands before leaving the room that was initiated on 10/22/24.<br><br>A review of the October 2024 OSR revealed a PO for the following:<br><br>-order date 10/21/24 for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 6 hours for SOB (shortness of breath).<br><br>-order date 10/21/24 for Isolation /Contact precaution in Single Room for MRSA every shift for MRSA.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -order date 10/21/24 to administer humidified air every shift to ensure that the water chamber and/or water bag are not allowed to run out of sterile water administer humidified air every shift via [name] machine at (20 ) degrees Celsius (4) L (liters)/minute ( )% O2 on at all times.<br><br>The above order for Ipratropium-Albuterol was transcribed and plotted to the October 2024 eMAR and signed by nurses as administered at 12 midnight, 6 AM, 12 noon, and 6 PM.<br><br>The above order for Contact Precaution was transcribed and plotted to the October 2024 eMAR and signed by nurses at 7-3 Day shift, 3-11 Evening shift, and 11-7 Night shift from 10/22 through 10/29/24 7-3 shift.<br><br>The above order to administer humidified air was transcribed and plotted to the October 2024 electronic Treatment Administration Record (eTAR) and signed by nurses at 7-3 Day shift, 3-11 Evening shift, and 11-7 Night shift from 10/21 through 10/31/24 7-3 shift.<br><br>On 10/31/24 at 8:57 AM, the surveyor interviewed the LPN. The LPN informed the surveyor that Resident #213's contact precaution for MRSA was discontinued and just forgot to remove the signs when the surveyor observed it on 10/29/24 when the RA exited the room. He further stated that the physician clarified that there was a history of MRSA and no active MRSA in the nares and trach. The LPN also stated that the order should have been an EBP and not contact precaution on 10/29/24. He further stated that still, the RA should have performed hand hygiene before exiting the resident's room.<br><br>On 10/31/24 at 9:00 AM, the surveyor and the Unit Clerk (UC) entered the resident's room and both observed the resident lying on the bed with a visitor at the bedside. The resident was awake but nonverbal. The surveyor also observed the neb mask was not in use, not inside a bag, and not stored properly. The neb mask was on top of the neb machine on top of the nightstand table, and the neb mask tubing was dated 10/28/24. The resident's O2 was set at 35 FIO2 (the fraction of inspired oxygen (FiO2) is the concentration of O2 in the gas mixture) attached to a humidified bottle via trach.<br><br>On 10/31/24 at 9:03 AM, the surveyor interviewed the LPN regarding Resident #213's O2 order and neb mask. The surveyor asked the LPN what was the order for O2 of the resident. The LPN checked the electronic medical records and showed: administer humidified air every shift ensure that water chamber and/or water bag are not allowed to run out of sterile water administer humidified air every shift via [name] machine at (20) degrees Celsius (4) L/minute ( )% O2 on at all times. The surveyor asked what was the 35 in the humidified bottle of the resident's O2 meant. The LPN stated that it was not in the order. The LPN further stated that the PO for O2 was incomplete, and it should have been clarified.<br><br>At that same time, the LPN stated that the Respiratory Therapist (RT) comes in once a week and will be at the facility tomorrow. He further stated that he would call and verify the order with the physician. The LPN stated that the neb mask when not in use should be stored in a bag and he will notify the other shift about it that should be in a bag.<br><br>(continued on next page) |

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| | 315290 | A. Building<br>B. Wing | 11/07/2024 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/04/24 at 12:05 PM, the surveyor in the presence of the survey team interviewed the Regional Infection Preventionist Nurse (RIPN) regarding the facility's standard of practice and procedure with neb mask or other respiratory care equipment and supplies in the resident's room when not in use how it should be stored. The RIPN stated that the neb mask when not in use should be inside a bag and changed weekly by the 11-7 shift nurse. She further stated that she had to verify what specific date they change it.<br><br>The surveyor then notified the RIPN of the above concerns and findings about the neb mask not being stored properly for Residents#210 and #213. The RIPN stated that the neb mask when not in use should be stored inside a bag for infection control.<br><br>On that same date and time, the surveyor also asked if the resident had posted a sign for contact precautions by the door and what would be the expectation for the staff and visitors to do. The RIPN stated that it was expected for visitors and staff to don (put on) PPE prior to entry room. The RIPN further stated that they should go to the nurse to verify the posted signs and instructions on what to do. She also stated that visitors and staff should perform hand hygiene prior to entering and exiting the room.<br><br>The RIPN stated that for the contact precaution sign and concerns about Resident #213, the RA should have followed the posted sign to perform hand hygiene before entering and leaving the room and donned PPE. The RIPN also stated that the status of the resident should have been clarified and updated with either Contact or EBP. She further stated that RA did not put on PPE and did not perform hand hygiene while Resident #213 had an order and posted signs for contact precautions. The RIPN also stated that there was no negative adverse effect.<br><br>Furthermore, the RIPN informed the surveyor that the RT came and discussed the O2 order and clarified the order. The RIPN further stated that according to the RT, the FIO2 at the time of observation had nothing to do with the resident's O2 intake and had no negative effect on the resident.<br><br>At that same time, the surveyor asked the RIPN what the expectation from visitors and staff for residents on EBP would be. The RIPN stated that it was expected that PPE was required on high contact care, and best practice to do hand hygiene prior to and before exiting the room.<br><br>On 11/06/24 at 11:19 AM, the survey team met with the LNHA, Director of Nursing (DON), and Regional Director of Operations (RDO). The surveyor notified the facility management of the above concerns and findings.<br><br>On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, AA, and RIPN. The DON stated that Resident #210 neb was not bagged because it was air drying. The RIPN stated that it was best practice after use to clean the mask with soap and water and put it on top of a clean paper towel, and once dry store it in the bag. The facility management acknowledged that the neb mask upon the surveyor's observation was not on a clean paper towel, it was directly placed in the resident's environment which was the nightstand table and neb machine.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On that same date and time, the RIPN stated regarding Resident #213, the facility immediately corrected the concerns about O2 orders and respiratory equipment use and obtained appropriate order for the trach resident. She further stated that the facility will initiate a performance improvement plan. The RIPN further stated that the order for contact precaution of Resident #213 should have been clarified to change it to EBP, otherwise, the RA should have followed the order and posted a sign for contact precaution.<br><br>A review of the facility's Nebulizer Therapy Policy with a revised dated 10/2023 that was provided by the DON revealed:<br><br>Policy: It is the policy of this facility for neb treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions.<br><br>Policy Explanation and Compliance Guidelines:<br><br>2. Care of the Equipment:<br><br>g. Once completely dry, store the neb cup and the mouthpiece in a zip lock bag.<br><br>A review of the facility's Transmission-Based Precautions with a revised date of 7/23/24 that was provided by the DON revealed:<br><br>Policy:<br><br>Definitions: TBP are group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively. There are three categories of TBP: contact, droplet, and airborne.<br><br>Policy Explanation and Compliance Guidelines:<br><br>3. Contact Precautions-<br><br>a. Intended to prevent transmission of infectious agents including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment .<br><br>d. Donning PPE upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination .<br><br>A review of the facility's Contact Precautions posted sign that was provided by the DON showed:<br><br>Everyone must:<br><br>Clean their hands, including before entering and when leaving the room.<br><br>Providers and Staff Must also:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Put on gloves before room entry.<br><br>Discard gloves before room exit.<br><br>Put on gown before room entry.<br><br>Discard gown before room exit .<br><br>A review of the facility's Enhanced Barrier Precautions Policy with a revised date of 3/07/2024 that was provided by the DON revealed:<br><br>Procedure:<br><br>b. Perform hand hygiene before entering and when leaving the room.<br><br>A review of the facility's Tracheostomy Care with a revision date of 9/2024 that was provided by the DON showed:<br><br>Policy: The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and resident goals and preferences.<br><br>Policy Explanation and Compliance Guidelines:<br><br>4. Based upon the resident assessment, attending PO, and professional standards of practice, the facility collaboration with the resident/resident's representative will develop CP that includes appropriate interventions for respiratory care.<br><br>On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, RDO, Regional Clinical Operations, and AA for the Exit Conference, and facility management did not provide any additional information.<br><br>NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>38327<br><br>Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a.) sufficient nursing staff and b.) incontinence care was provided for two (2) of two (2) residents (Residents #67 and #214) in a timely manner, during the incontinence tour.<br><br>This deficient practice was evidenced by the following:<br><br>1. On 10/29/24 at 9:04 AM, the survey team entered the facility and met with the Receptionist. The surveyor observed a posted Nursing Home Resident Care Staffing Report (NHRCSR) dated 10/29/24 Day Shift, 7:00 AM-3:00 PM (7-3), current Census 158, total of 13 CNAs, and staff to resident ratio of 1 CNA:12.2 Residents.<br><br>On 10/29/24 at 10:21 AM, the surveyor observed Resident #140 lying on the bed with the responsible party (RP) at the bedside. The RP informed the surveyor that there were no care issues except that the facility was short of staff. The RP stated that yesterday morning, only one Certified Nursing Aide (CNA) worked in the unit (Penthouse) for a total of 18 residents. The RP further stated that it had been a struggle at the facility especially on the weekends.<br><br>A review of the provided nursing schedule for 10/28/24 revealed census 158, Penthouse unit 18 residents, and one CNA.<br><br>On 10/30/24 at 8:25 AM, the Receptionist provided a copy of the NHRCSR's census and staff-to-resident ratio, and revealed the following:<br><br>-NHRCSR 10/26/24 (Saturday) 7-3 Day Shift: census 159, 1 RN:32.6 Residents, 1 LPN:30.3 Residents, 1 CNA:15.9 Residents<br><br>-NHRCSR 10/26/24 (Saturday) 3:00 PM-11:00 PM (3-11) Evening Shift: census 159, 1 RN:24 Residents, 1 LPN:36.9 Residents, 1 CNA:19.9 Residents<br><br>-NHRCSR 10/26/24 (Saturday) 11:00 PM-7:00 AM (11-7) Night Shift: census 159, 1 RN:66.9 Residents, 1 LPN:37.4 Residents, 1 CNA:22.7 Residents<br><br>-NHRCSR 10/27/24 (Sunday) Day Shift: census 159, 1 RN:33 Residents, 1 LPN:37.4 Residents, 1 CNA:19.9 Residents<br><br>-NHRCSR 10/27/24 (Sunday) Evening Shift: census 159, 1 RN:37.4 Residents, 1 LPN:30.3 Residents, 1 CNA:22.7 Residents<br><br>-NHRCSR 10/27/24 (Sunday) Nigh Shift: census 159, 1 RN:70.7 Residents, 1 LPN:36.9 Residents, 1 CNA:22.7 Residents<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/04/24 at 6:26 AM, the surveyor entered the facility in the presence of Registered Nurse #1 (RN#1). There was no receptionist at the desk. The surveyor observed the posted NHRCSR dated 11/03/24 with the census of 158 and revealed the following information:<br><br>-Night Shift, 11-7 shift,<br><br>-Staff Category: RN, #of Staff: 3, Start & End Times: 11 PM-7 AM, Staff to Resident Ratio: 1 RN:47.7 Residents<br><br>-Staff Category: LPN, #of Staff: 3, Start & End Times: 11 PM-7 AM, Staff to Resident Ratio: 1 LPN:48.6 Residents<br><br>- Staff Category: CNA, #of Staff: 6, Start & End Times: 11 PM-7 AM, Staff to Resident Ratio: CNAS:26.3 Residents<br><br>On 11/04/24 at 6:30 AM, the surveyor met with the RN Supervisor (RNS) from the 11-7 shift in the 1 South unit. The RNS informed the surveyor that the census from midnight was 161 and stated the following:<br><br>-1 West=census 18 with 1 LPN and 1 CNA<br><br>-2 North=census 47 with 1 nurse and 1CNA<br><br>-2 South=census 37 with 1 LPN and 1CNA<br><br>-1 South=census 40 with 1 nurse and 1CNA<br><br>-Penthouse=census 18 with 1 RN and 1CNA<br><br>A review of the facility's assignments of the CNAs by unit that was provided by the DON showed:<br><br>-11/03/24 Sunday total census of 161<br><br>-11-7 Penthouse=1 CNA and 1 LPN<br><br>On 11/04/24 at 6:55 AM, the surveyor interviewed LPN#1 from 1 South in the nursing station. The LPN informed the surveyor that she was the assigned nurse at 1 South for the 11-7 shift last night (Sunday), and confirmed that there was one nurse and 1 CNA (CNA#1). The LPN stated that usually there were 2-3 CNAs at the 11-7 shift. The LPN stated that for the last three months probably 3x it happened that only one CNA worked for the 11-7 shift. She further stated that it usually happened during weekends but not on weekdays.<br><br>On 11/04/24 at 7:35 AM, the surveyor interviewed LPN#2 from 1 West. LPN#2 informed the surveyor that he was the 11-7 nurse last night (Sunday, 11/03/24). The LPN stated that the 1 [NAME] census was 18, one nurse (himself) and one CNA (CNA#2). The LPN further stated that was the usual staffing at 1 West, one nurse and one CNA.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. On 11/04/24 at 6:42 AM, the surveyor and the RNS went to Resident # 67's room, with the door closed. There was a strong smell of urine outside the door. The surveyor asked the RNS and she confirmed that there was a smell of urine. Upon entry to the room, CNA#1 was inside the room providing morning (am) care to Resident #67. The surveyor asked the RNS to check the used diaper of the resident and the incontinence pad. The RNS, inside the resident's toilet room, showed the surveyor two soaked and wet diapers (yellow), a white bedsheet, and a blue chuck (cloth type) soaked and wet urine. The surveyor asked the RNS if the resident should have a double diaper and the RNS responded that they were not allowed to wear double diapers and CNA should not do that. The RNS confirmed that the double diaper and incontinence pads (sheet and the blue chuck) were soaking wet.<br><br>During an interview with CNA#1, the CNA confirmed that she was the only CNA for the 11-7 shift. The CNA was unable to further talk to the surveyor because she had to finish the am care.<br><br>Outside the resident's room, the surveyor interviewed the RNS. The RNS stated that the resident was cognitively impaired and incontinent of both bladder & bowel elimination. She further stated that the resident should not have double diaper. The RNS had no answer when asked by the surveyor why Resident #67 was soaking wet.<br><br>On 11/04/24 at 6:50 AM, the surveyor and the RNS went to Resident #214's room and observed CNA#3 almost finish with am care with the resident. The surveyor asked the RNS and the CNA where the used diaper of the resident was. The RNS showed the surveyor the used diaper and the diaper was soaking wet with urine. The surveyor asked the RNS about the diaper and the RNS acknowledged that the diaper was soaking wet.<br><br>At that time, the surveyor interviewed CNA#3. The CNA stated that she was the only CNA in the unit for the 11 PM-7 AM shift and had all residents in their assignment. CNA#3 was unable to state how many total residents. The surveyor asked how many times she had to change residents in the unit, and she stated that she should change them at least 2x in a shift. She further stated that she started the 1st round of incontinence care at 11:15 PM and then the next round at 3:45 AM and that she needed to start early in order to finish all residents. The CNA acknowledged it was hard for one CNA for the entire unit.<br><br>Outside the resident's room, the surveyor interviewed the RNS. The RNS informed the surveyor that Resident #46 and Resident #214 were both cognitively impaired and incontinent. She further stated that Resident #214 was recently admitted maybe 2 or 3 weeks ago. The RNS informed the surveyor that there was a total of 37 residents in 2 South unit with 1 LPN and 1 CNA, and CNA#3 had all 37 residents in her assignment. The surveyor asked for a copy of the schedule for 11 PM-7 AM and the assignment and she stated that she will get back to the surveyor.<br><br>On 11/06/24 at 11:19 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Director of Operations (RDO). The surveyor notified the facility management of the above concerns with staffing and concerns with the incontinence care tour that Residents#67 and #214 were soaking wet.<br><br>On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, Assistant Administrator (AA), and the Regional Infection Preventionist Nurse (RIPN). The DON stated that the residents should not be soaking wet.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's Incontinence Policy with a revised date of 8/2023 that was provided by the DON revealed:<br><br>Policy: Based on the resident's comprehensive assessment, all residents who are incontinent will receive appropriate treatment and services.<br><br>Policy Explanation and Compliance Guidelines:<br><br>4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.<br><br>On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, RDO, RCO, and AA for the Exit conference. The facility did not provide additional information and did not refute the findings.<br><br>NJAC 8:39-25.2(a,b) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>38327<br><br>Based on interviews, and a review of pertinent facility documents, it was determined that the facility failed to ensure that a non-certified Nursing Aide (NA #1) received the required training and competencies needed prior to receiving their own assignment and rendering resident care which included but not limited to; bathing, toileting, transferring, feeding, personal hygiene, and grooming. This was identified for 1 of 9 NAs reviewed (NA#1) who provided direct care to residents on 5 of 5 nursing units.<br><br>NA #1 was hired on 6/17/24, as a Hospitality Aide. NA #1 began independent resident care assignments on 7/03/24, and was enrolled in a state approved Nurse Aide in Long-Term Care Facilities Training and Competency Evaluation Program (NATCEP) that began on 7/15/24, and worked 69 shifts with no evidence of completing the required skills and competencies prior to providing resident care.<br><br>The facility's failure to ensure all NAs were trained with the appropriate competencies and skills required prior to receiving an independent resident care assignment posed a likelihood that serious injury, harm, impairment, or death could occur to residents since untrained staff were providing resident care. This resulted in an Immediate Jeopardy (IJ) situation.<br><br>The IJ began on 7/03/24, after NA #1 was assigned as a NA on the 2 North nursing unit. The facility Administration was notified of the IJ on 11/01/24 at 5:44 PM. The facility submitted an acceptable Removal Plan (RP) on 11/06/24 at 3:42 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 11/07/24.<br><br>The evidence was as follows:<br><br>A review of the facility provided Position Title: Nursing Assistant (NA) job description dated August 2005, included; the Nursing Assistant performs various resident care activities and related nonprofessional services essential to caring for the personal needs and comfort of resident .Job skills and requirements .must have knowledge of procedures and techniques in administering simple treatments and providing related bedside resident care services .must understand standard techniques used in providing personal services and in caring for equipment and supplies .<br><br>A review of the undated facility provided Hospitality Aide job description included; a Hospitality Aide is responsible for assisting in the care of residents in a healthcare or long-term care facility. This may include helping patients with activities of daily living, serving meals, cleaning rooms, and providing companionship and emotional support. Key responsibilities: serve meals [ .] not allowed to feed; maintain a clean and organized living space for residents .greeting guests and aiding with their needs not allowed to change or bathe/shower residents .answer call light and report the request(s) to nurse or CNA .pass out water .<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 10/29/24 at 11:02 AM, during the entrance conference with the Licensed Nursing Home Administrator (LNHA), Registered Nurse/Unit Manager (RN/UM), and Assistant Administrator (AA), the surveyor asked if the facility utilized non-certified Nurse Aides (NAs), and the Director of Nursing (DON) responded yes. The surveyor also asked if the NAs were providing direct care to residents, and the LNHA stated that the NAs were not providing direct care because they were not done in school, or did not have a license yet. The LNHA stated the NAs were only passing water and helping to transport residents. The LNHA further stated that he was unsure of how many NAs were in the facility and that he would provide a list.<br><br>On 10/29/24 at 01:10 PM, the LNHA provided the surveyor with a list of NAs who worked at the facility. NA #1 was included on the list with a date of hire (doh) of 6/17/24.<br><br>On 10/30/24 at 01:14 PM, the surveyor reviewed NA #1's employee file which revealed the following:<br><br>-Human Resources New Hire Form: doh 6/17/24. Position: Hospitality Aide, hourly, full time with benefits, scheduled hours 7:00 AM to 3:00 PM (7-3).<br><br>-Job Title and Description: Hospitality Aide. Key responsibilities: did not include direct care. Signed by NA #1 on 6/17/24.<br><br>-Job Description, Position Title: Nursing Assistant (NA), signed by NA#1 on 10/06/24.<br><br>-School letter dated 5/15/24: This letter is to certify NA #1 will be attending the CNA training course at [name of school redacted] starting July 15th, 2024 to [August] 15th, 2024, Monday through Friday from 9:00 AM to 2:30 PM. Ninety hours were required in order to complete this program. Signed by the School Director (SD).<br><br>-Personnel Change Form: doh 6/17/24, today's date 10/09/24, change effective date 10/06/24. Nature of change: reclassification, new title: Nurse Aide. Signed by Human Resources (HR): changes completed 10/09/24.<br><br>Further review of NA #1's employee file did not include documented evidence that NA #1 completed the 16 hours or 90 hours of required education, training, and competencies in order to provide direct care to residents.<br><br>A review of NA #1's time sheets provided by the Human Resource Regional Director (HRRD #1) revealed NA #1 worked the following:<br><br>-From 6/17/24 to 7/14/24, NA #1 worked the 7:00 AM to 3:00 PM (7-3) shift Monday through Friday. In addition, NA #1 worked the 7-3 on 6/29/24; the 7-3 and 3:00 PM-11:00 PM (3-11) double shifts on 7/04/24, and the 7-3 and 3-11 double shifts on 7/13/24.<br><br>-From 7/15/24 to 8/15/24, NA #1 worked the 7-3 shift Monday through Friday. In addition, NA #1 worked the 7-3 and 3-11 double shifts on 7/19, 7/29, 7/31, 8/05, 8/09, and 8/14/24. NA #1 also worked on 7/27/24 and 8/03/24, the 7-3 shift.<br><br>A review of the corresponding Certified Nursing Aide (CNA) assignments sheets provided revealed the following:<br><br>(continued on next page) |

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| | 315290 | A. Building<br>B. Wing | 11/07/2024 |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On the 7/01/24, 7-3 shift, NA #1 was independently assigned to Assignment #2 which included 13 residents in total and showers for three residents (rooms: 128 A, 136 A, and 138 A).<br><br>A review of the additional CNA assignment sheets confirmed NA #1 worked on all five nursing units with independent resident care assignments that corresponded with their timesheets.<br><br>According to NA #1's school letter, NA #1 was attending the CNA school Monday through Friday from 9:00 AM to 2:30 PM, beginning 7/15/24 through 8/15/24. According to the facility's CNA assignment sheets and NA #1's time card, NA #1 was working at the facility providing resident care during the same dates and time NA #1 was supposed to be attending school.<br><br>On 10/31/24 at 9:49 AM, the surveyor conducted a telephone interview with NA #1, who stated she was unsure when she started and ended nurse-aide training school. NA #1 confirmed that she was not currently enrolled in school and did not complete school. NA #1 stated that she was unable to finish the school program because she was at the facility working double shifts most of the time. NA #1 further stated that when she started working in the facility, she had three weeks maybe of orientation following a CNA, and then afterwards she had her own independent resident care assignment providing direct care which included; washing, toileting, feeding, and transferring residents from bed to wheelchair and vice versa. NA #1 stated that according to HRRD #1, she was not allowed to return to work until she was able to provide documentation that she completed the required NATCEP program because the facility did not have those documents.<br><br>On 10/31/24 at 12:02 PM, the surveyor interviewed HRRD #1 and HRRD #2. HRRD #1 stated that according to the information received from the school, NA #1 was scheduled to start on 7/15/24. HRRD #1 continued that NA #1 would have completed their 16 hours of competency skills on 7/18/24. HRRD #2 stated that NA #1 could provide resident direct care supervised by a CNA. HRRD #2 also stated in regards to NA #1's title change in October, that on 7/15/24, NA #1's title should have changed then from Hospitality Aide to NA because she was enrolled in school, and the delay in title change was an error.<br><br>At that time, the facility was unable to provide documentation that NA #1 completed their competency skills. HRRD #1 and HRRD #2 did not respond to surveyor inquiry how the facility would know NA#1 completed their competency skills with no documentation.<br><br>On 10/31/24 at 01:51 PM, the surveyor interviewed the RN/UM, who stated that NA #1 went to school, did not pass, or take the test, and cannot be a CNA. The surveyor then reviewed with the RN/UM the CNA assignments for the 2 North unit where NA #1 on 10/8, 10/11, 10/14, 10/15, 10/16, and 10/18/24, was assigned with room numbers below NA #1's name and the surveyor asked what that meant. The RN/UM responded that the assignments indicated that NA#1 was assigned to provide direct care to those residents in the corresponding rooms. The RN/UM confirmed NA #1 was not supposed to have an assignment because she was a NA, and it was the nurses in the unit who assigned NA#1 to a resident care assignment.<br><br>On 10/31/24 at 02:24 PM, HRRD #1 and HRRD #2 provided a letter from NA#1's school dated 10/31/24, that included Sorry she (NA #1) did not complete her program. She missed the Test one and the Final. Additionally, she failed to pay her balance. She did not complete the class. The letter was signed by the SD.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On that same date and time, HRRD #1 confirmed that NA #1 should not have an assignment on their own. The surveyor showed HRRD #1 and HRRD #2 the CNA assignment sheets where NA #1 had resident care assignments, and they both acknowledged that NA #1 should not have had their own care assignment.<br><br>On 10/31/24 at 3:25 PM, the surveyor reviewed the CNA Assignment sheets with the 7-3 Registered Nurse (RN) and the 3-11 Licensed Practical Nurse (LPN) in the 2 North nursing unit. The RN confirmed that NA #1 worked independently with assigned residents providing direct care on 7/03, 7/17, and 7/18/24, for the 7-3 shift. The LPN confirmed that NA #1 worked independently with assigned residents providing direct care on 10/4, 10/11, and 10/15/24, during the 3-11 shift.<br><br>At that same time, both nurses stated that as per facility practice, they (nurses) assigned the aides when they received the schedule for the day on their shifts. Both further stated that it did not matter if they were CNAs or NAs, both aides had their own assigned residents and assignments to provide direct care, i.e. feeding, toileting, transferring, and bathing/washing of the residents. The RN confirmed that NA #1 had their own assignments and provided direct care independently. The surveyor asked how they knew that NA #1 could work independently on their assignment, and both the RN and LPN stated that when they received the schedule for their shifts, they divided the assignments accordingly and nobody told them, they just knew.<br><br>On 11/01/24 at 8:13 AM, the surveyor followed up with HRRD #2 regarding the requested policies for Hospitality Aides and Nursing Aides. The surveyor also requested the facility's policy regarding the onboarding process. HRRD #2 stated she would get back to the surveyor.<br><br>On 11/01/24 at 8:21 AM, the surveyor asked the DON what the facility's process for onboarding NAs was, and the DON stated the usual process, was the NA applied, a criminal background check was performed, health physicals and testing was done, and the facility verified they were in school. The DON stated the facility needed to receive the documentation that the NA was attending school. She further stated, I think when they're in school, they have to take the skills test they have to submit the skills test and whatever they are doing in school.<br><br>On that same date and time, the surveyor asked the DON why it was important that the facility received documentation that the NA completed their skills test, and the DON stated because the NAs needed to be competent to do the care. The surveyor also asked the DON if the facility provided competencies skill to the NAs, and the DON stated that there was no specific time when the facility provided or checked NAs competency skills. She further stated that if NA brought their skills test from school, the NA could provide direct care as soon as the facility received it. The DON confirmed the skills test and competencies should be included in their employee file. The surveyor asked the DON if she checked the NAs' files to ensure they had their completed requirements, and the DON stated that the nurses and herself checked the files.<br><br>On 11/01/24 at 9:32 AM, HRRD #2 stated that the facility did not have a policy for Hospitality Aides and NA; that the facility followed their job description.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | On 11/01/24 at 10:40 AM, the surveyor interviewed HRRD #1, who stated that she was responsible for ensuring all required newly hired employee documents were together; ran background checks; called the NA for orientation; and entered all the NA's information into the system. HRRD #1 stated that it was the Staffing Coordinator's (SC) responsibility to verify the NA's school requirements and documents prior to date of hire and resident care. The SC was also responsible for ensuring a copy of the verification was included in the NA's employee file. HRRD #1 confirmed NA #1 did not have the skills test and NA #1 should not have been providing direct resident care. HRRD #1 stated the SC was out of the facility on leave.<br><br>On 11/01/24 at 11:19 AM, the surveyor asked the LNHA what the facility required the NAs to submit prior to hire and be able to provide direct resident care, and the LNHA stated he was not involved in the NA onboarding process. The LNHA stated his role as the administrator was to approve and sign documents for the onboarding of newly hired employees so he was unaware of what was included in the process.<br><br>On 11/04/24 at 9:39 AM, the surveyor met with the LNHA, DON, and Regional Director of Operations (RDO). The DON stated that the facility was only responsible for receiving the information from the NA that they were enrolled in school; that we go by the information provided by the NA.<br><br>An acceptable Removal Plan (RP) on 11/06/24 at 3:42 PM, indicated the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including NA #1 was removed from employee schedule pending confirmation of successfully passing exam; staff education on hiring Hospitality Aides and the process for hiring and scheduling Nursing Aides; DON reviewed all current NA onboarding requirements; and DON reviewed all NAs to confirm they had the required competency skills.<br><br>The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 11/7/24.<br><br>N.J.A.C. 8:39-43.1 (a)(2,3); 43.2(a)(1,3)(b) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>38327<br><br>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for three (3) of seven (7) days. This failure could affect the knowledge of the availability of staff to care for the residents, resident representative, and visitors.<br><br>This deficient practice was evidenced by the following:<br><br>On 10/29/24 at 9:04 AM, the survey team entered the facility and met with the Receptionist who instructed surveyors to use the stand-alone thermometer and fill out the paper for COVID screening. The surveyor observed a posted Nursing Home Resident Care Staffing Report (NHRCSR) dated 10/29/24 Day Shift, 7 AM-3 PM, current census of 158 that included 13 CNAs (Certified Nursing Aides) with staff to resident ratio of 1 CNA:12.2 Residents.<br><br>On 10/29/24 at 9:20 AM, the Registered Nurse Supervisor (RNS) informed the surveyor in the presence of the survey team that the census (total number of residents) was 156.<br><br>On 10/30/24 at 8:17 AM, the surveyor entered the facility and met with the Receptionist who provided a copy of the NHRCSR dated 10/30/24. The NHRCSR dated 10/30/24 census was 158 and revealed the following information:<br><br>-Day Shift 7 AM-3 PM<br><br>-1 RN (Registered Nurse):26.9 Residents,<br><br>-1 LPN (Licensed Practical Nurse):17.7 Residents,<br><br>-11 CNA, 1 CNA:14.4 Residents.<br><br>On 10/30/24 at 12:18 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of another surveyor regarding staffing. The surveyor verified and asked the LNHA what the asterisk meant in the schedule that was previously provided to the surveyor. The surveyor showed the schedule dated 10/29/24. The LNHA stated the asterisk meant that they were noncertified nursing aides (NA).<br><br>On that same date and time, the surveyor asked the LNHA why there was a discrepancy with the submitted Nursing schedule for 10/29/24 for a total of 11 CNAs, and on the posted NHRCSR it showed that there were 13 CNAs in the 7-3 Day shift on 10/29/24. The LNHA counted the CNAs and the NAs in the schedule for 10/29/24. The LNHA stated that two NAs equals one CNA. The surveyor then asked the LNHA, if two NAs equal one CNA, it was not accurate for the 13 CNAs because the schedule had a total of seven NAs for the 7 AM-3 PM shift.<br><br>At that same time, the surveyor asked the LNHA why there was a discrepancy on the census list provided during entrance conference and what was posted on 10/29/24 NHRCSR. The LNHA had no answer.<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Furthermore, the surveyor asked the LNHA who was responsible for posting the NHRCSR, and he said it was the Staffing Coordinator (SC).<br><br>On 10/30/24 at 12:34 PM, the surveyor interviewed the SC in the presence of the two surveyors, and the Regional Clinical Operation (RCO). The SC informed the surveyor that she was covering for the full-time SC for almost two weeks. She further stated that she was also a Unit Clerk (UC). The UC stated that the full-time SC was on vacation since 10/11/24 and will be back in December.<br><br>On that same date and time, the surveyor asked the UC what the facility's process with regard to NHRCSR was. The UC informed the surveyor that when she comes in at 8 AM, go online to check payroll to determine who clocked in, goes to the NHRCSR site, and puts the numbers according to the clocked-in of the staff. She stated that for example, for 10/30/24 today, the UC will review the 10/29/24 punches (time in and out of staff), and then estimate from 10/29/24 information the information that will be entered for 10/30/24 for census and staff that was why the census and number of staff did not match when the surveyor observed the posted NHRCSR on 10/29/24 because those information were from the day before.<br><br>At that time, the RCO stated that to the UC that was not how it should be done. The RCO acknowledged that the posted NHRCSR should be accurate and not estimated. The surveyor asked the UC how she came up with 13 CNAs for 10/29/24 for the Day shift. The UC stated that according to what was explained to her by the full-time SC before, she counted NAs (the one with an asterisk while checking the paper for 10/29/24), and two NAs equal one CNA. The RCO also stated that it was not correct to count two NAs equal to one CNA, and that education would be provided to the UC.<br><br>A review of the provided Nursing schedule of the LNHA on 10/29/24 at 12:10 PM revealed:<br><br>-Week 2, Tuesday, 10/29/24: total of 11 CNAs<br><br>A review of the provided Nursing schedule of the LNHA on 10/30/24 at 02:02 PM revealed:<br><br>-Week 2, Wednesday, 10/30/24: total of 9 CNAs<br><br>A review of the provided alphabetical list and census list of the LNHA on 10/29/24 at 10:20 AM showed a total census of 156 from midnight census.<br><br>A review of the provided alphabetical list and census list of the LNHA on 10/31/24 at 9:55 AM showed a total census of 158 from midnight census.<br><br>On 11/04/24 at 6:26 AM, the surveyor entered the facility in the presence of the Registered Nurse (RN). There was no Receptionist at the desk. The surveyor observed the posted NHRCSR dated 11/03/24 with the census of 158 and revealed the following information:<br><br>-Night Shift, 11-7 shift,<br><br>-Staff Category: RN, #of Staff: 3, Start & End Times: 11 PM-7 AM, Staff to Resident Ratio: 1 RN:47.7 Residents<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Staff Category: LPN, #of Staff: 3, Start & End Times: 11 PM-7 AM, Staff to Resident Ratio: 1 LPN:48.6 Residents<br><br>- Staff Category: CNA, #of Staff: 6, Start & End Times: 11 PM-7 AM, Staff to Resident Ratio: 1 CNA:26.3 Residents<br><br>On 11/04/24 at 6:30 AM, the surveyor met with the RNS from the 11-7 shift in the 1 South unit. The RNS informed the surveyor that the census from midnight was 161 and stated the following:<br><br>-1 West=census 18 with 1 LPN and 1 CNA<br><br>-2 North=census 47 with 1 nurse and 1 CNA<br><br>-2 South=census 37 with 1 LPN and 1 CNA<br><br>-1 South=census 40 with 1 nurse and 1CNA<br><br>-Penthouse=census 18 with 1 RN and 1 CNA<br><br>A review of the facility's assignments of the CNAs by unit that was provided by the DON showed:<br><br>-11/03/24 Sunday total census of 161<br><br>-11-7 Penthouse=1 CNA and 1 LPN<br><br>-11-7 1 West=1 CNA and 1 RN<br><br>-11-7 1 South=1 CNA and 1 LPN<br><br>-11-7 2 South=1 CNA and 1 LPN<br><br>-11-7 2 North=1 CNA and 1 RN<br><br>On 11/06/24 at 11:19 AM, the survey team met with the LNHA, Director of Nursing (DON), and Regional Director of Operations (RDO). The surveyor notified the facility management of the above concerns with the posted NHRCSR discrepancies on 10/29, 10/30, and 11/03/24.<br><br>On 11/07/24 at 9:29 AM, the DON provided a copy of the NHRCSR and stated that the top portion of the form which showed Notice to Consumer was what the facility followed for posting Nurse Staffing report and there was no other policy.<br><br>A review of the Notice to Consumer from the NHRCSR revealed:<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | P.L. 2005 c. 21, $$1, 2 and 3 (the Act), approved on January 24, 2005, codified at N.J.S.A 26L2H-5f, 5g, and 5h, required long-term care facilities, commonly known as nursing homes, licensed in accordance with the Health care Facilities Planning Act, N.J.S A 26:2H-1 et seq., to post and make available to the public direct resident care staffing levels within the facilities and to report staffing level information to the Department. This information shall be displayed in a place where residents and the general public can easily view it.<br><br>On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, Assistant Administrator (AA), and the Regional Infection Preventionist Nurse (RIPN). The DON stated that the facility followed the guidelines in posting the NHRCSR that was previously provided and explained to the surveyor. The surveyor asked the facility management should the posted NHRCSR be accurate. The DON stated that it depends, and it changes, but updated daily by SC (also known as the UC). The DON further stated that on Friday the UC does the prediction and if there was a call out then she communicated to the supervisor and the supervisor should update the staffing the same day.<br><br>On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, RDO, RCO, and AA for the Exit conference. The facility did not provide additional information and did not refute the findings.<br><br>N.J.A.C. 8:39-41.2 (a)(b)(c)(d) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51226<br><br>Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to administer the medication to Resident #45 due to unavailability of the medication. The deficient practice was identified for one (1) of four (4) residents (Resident #45) observed during medication administration. The Resident did not received medication for mood disorder at the prescribed time.<br><br>The deficient practice was evidenced by the following:<br><br>On 11/04/24 at 7:50 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepared medication (med) of Resident #45. The LPN was unable to administer the med Seroquel 12.5 mg (milligram) to the Resident due to unavailability. The LPN acknowledged that the Seroquel 12.5 mg was not available in the med cart. The LPN informed the surveyor that she would call the pharmacy to deliver the med as soon as possible (ASAP).<br><br>The surveyor reviewed the medical record of Resident #45.<br><br>The Admission Record revealed that the resident was admitted to the facility and had a diagnoses of Alzheimer's Disease (condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning.)<br><br>The quarterly Minimum Data Sets (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07 out of 15 which indicated that the resident's cognitive status was severely impaired.<br><br>A review of the November 2024 electronic Medication Administration Record (eMAR) revealed that Seroquel 12.5 mg at 9:00 AM was not administered as scheduled on 11/04/24.<br><br>Further review of the November 2024 eMAR revealed that the Seroquel was administered at 01:39 PM on 11/04/24. A physician order (PO) dated 11/04/24 revealed an order to administer the Seroquel 12.5 mg when the med becomes available.<br><br>A review of the med delivery receipt copy revealed that the last med delivery for Seroquel 12.5 mg was on 10/24/24.<br><br>On 11/06/24 at 11:30 AM, the surveyor notified the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA), and the Regional Director of Operations (RDO) of the above concern that the Seroquel 12.5 mg med was not available for Resident #45 during med administration observation.<br><br>NJAC 8:39-29.6 |

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|---|---|---|---|
| | 315290 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Buckingham at Norwood, The | 100 McClellan Street<br>Norwood, NJ 07648 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>49078<br><br>Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for one (1) of five (5) residents reviewed, (Resident #73).<br><br>The deficient practice was evidenced by the following:<br><br>The surveyor reviewed Resident #73's electronic medical record (EMR) which revealed the following:<br><br>Resident #73's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to chronic kidney disease, (when the kidneys are damaged and can't filter blood the way they should) and urinary tract infection.<br><br>Resident #73's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/15/24, reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify cognitive condition, score of 0 out of 15, which indicated that Resident #73 was severely cognitively impaired.<br><br>The resident's list of medications reflected a Physician's order (PO) for Vancomycin Oral Suspension, 50 mg/ml (milligram/milliliter), give 2.5 ml by mouth four times a day for c-diff (inflammation of the colon caused by the bacteria Clostridium difficile). Originally ordered for a duration of ten (10) days that was started on 10/09/24.<br><br>The list also revealed an order for Cefadroxil 500 mg (an antibiotic) that was given twice a day between the dates of 9/25/24 through 10/01/24.<br><br>A review of the manufacturer indications for Vancomycin (an antibiotic used treat infections) revealed that when used orally, Vancomycin can be used to treat an intestinal infection caused by a bacteria called Clostridium (c-diff).<br><br>The resident's EMR revealed a lab (laboratory) test result for C.DIFF TOXINS dated 10/11/24 that reflected a result of NEGATIVE.<br><br>The resident's progress notes revealed that there were no documented evidence of the justification of continued use of the antibiotic Vancomycin.<br><br>A physician progress note dated 10/08/24 at 12:43 PM marked as late entry with a created date of 11/06/24 at 12:51 PM, created and entered after surveyor inquiry, that reflected I was informed by the nurses that the patient is having bloody diarrhea, with mucos. patient was on PO antibiotics post laceration, labs showed leukocytosis on 10/6. C diff is suspected, will start vancomycin, patient at risk of bowel perforation if not treated. discuss with his family and the nursing staff, patient had bloody mucous discharge, will follow up labs vancomycin 125 mg q (every) 6 hours for 10 days. encourage fluid intake.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician progress note dated 10/12/24 at 8:04 AM marked as late entry with a created date of 11/07/24 at 8:12 AM and entered after surveyor's inquiry that reflected follow up note. patient with po antibiotics for one week for hands wounds, presented with diarrhea and leukocytosis and bloody mucos stool there was difficulty in collecting the stool , because its is absorbed in the diaper. specimen was collected from the diaper four days after starting the vancomycin, will continue with vancomycin since the bloody stool stopped, no more diarrhea, patient leukocytosis improved. patient mental status improved. patient was on po antibiotics bloody mucos diarrhea worsening of mental status leukocytosis collection technique was from the diaper 4 days after starting treatment. risk of delaying the treatment outweigh the benefit.<br><br>The surveyor reviewed the facility Antibiotic Stewardship Binder.<br><br>The binder revealed a tracking sheet with the resident's name. The tracking sheet reflected documentation under the resident's name of Presumptive CDiff, LABS NEGATIVE TO CDIFF and the order for Vancomycin. The binder also revealed an Infection Surveillance Checklist. The checklist revealed, under Table 5, a written note that reflected negative labs and awaiting on physician's response, and a checked box that reflected Diarrhea: > 3 liquid or watery stools above what is normal for the resident within 24h (hour).<br><br>On 11/06/24 at 12:12 PM, the surveyor interviewed the Regional Infection Preventionist Nurse (RIPN). The RIPN stated that the physician should document justification of use of antibiotics and follow up should occur to de-escalate or continue the antibiotic. She also stated that the antibiotic stewardship surveillance form or progress form should contain follow up for justification of use of the antibiotic with negative test result. The physician should document the reason for continuing or the nurse should document reason given by the physician for continuing the antibiotic.<br><br>On 11/06/24 at 01:36 PM the surveyor interviewed the RIPN. The RIPN showed the surveyor a paper copy of the lab results with a note that matches a note in the resident's EMR that nurse called the physician and the physician stated to continue the Vancomycin. No reason was observed on the copy that was shown to the surveyor. The RIPN stated that the physician has put in the resident's EMR a LATE ENTRY documentation. The RIPN agreed that this documentation was after the surveyor's inquiry.<br><br>A review of the facility's Antibiotic Stewardship Program Policy, dated 9/2022 revealed:<br><br>Policy reflected under #4. Line v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. Line vi. Reassessment of empiric antibiotics is conducted after 2-3 days for appropriateness and necessity, factoring in results of diagnostic test, laboratory reports, and/or changes in the clinical status of the resident.<br><br>On 11/07/24 at 01:07 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA). The LNHA stated there was no further information to be provided.<br><br>N.J.A.C. 8:39-27.1(a) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>38327<br><br>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) properly store medication (med) for one (1) of 38 residents, Resident #210, and b.) ensure that medications (meds) were stored and labeled appropriately for two (2) of four (4) med carts inspected and two (2) of four (4) med storage rooms inspected located on four (4) of five (5) nursing units according to facility's policy and standard of clinical practice.<br><br>This deficient practice was evidenced by the following:<br><br>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 and potential physical and emotional health problems, through such services as case-finding, 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.<br><br>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 case finding; 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.<br><br>1. On 10/29/24 at 10:35 AM, the surveyor observed Resident #210 inside their room seated in a wheelchair. The resident was cognitively intact and informed the surveyor that they were at the facility for rehabilitation. The surveyor observed three containers of meds on top of the drawers, L-Lysine (an essential amino acid; a supplement) 1000 mg (milligram), Vitamin D3 (supplement supports healthy bones and glowing skin, boosts immunity, and promotes heart health) 2000IU (2000 international unit), and Vitamin B12 (supplement; is important for protein metabolism) 1000 mcg (microgram).<br><br>The resident was in a private room by themselves. The resident stated that they were taking those home meds Vit D3 and Vit B12 once a day while at the facility for a while (unable to state the exact date).<br><br>On 10/29/24 at 10:45 AM, the surveyor asked the Licensed Practical Nurse (LPN) for the resident's list of meds in the electronic Medication Administration Record (eMAR). The LPN showed the surveyor the resident's meds inside the medication (med) cart that belonged to Resident #210. The provided copies of the resident's meds and actual meds in the med cart for Resident #210 revealed that the resident had no order for L-lysine, Vitamin D3, and Vitamin B12.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At that same time, the surveyor notified the LPN about the concerns that the resident had three containers of meds not properly stored. The LPN stated that he was unaware that the resident had meds on their own at the bedside. The LPN confirmed that there were no orders for L-lysine, Vitamin D3, and Vitamin B12 meds. The LPN further stated that there should be no meds left or stored in the resident's room.<br><br>The surveyor reviewed the medical records of Resident #210 and revealed:<br><br>The Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to other asthma (a condition in which a person's airways become inflamed, narrow, and swell, and produce extra mucus, which makes it difficult to breathe), unspecified diastolic (congestive) heart failure, and essential (primary) hypertension (occurs when abnormally high blood pressure that's not the result of a medical condition).<br><br>The most recent comprehensive Minimum Data Set (cMDS) with an assessment reference date (ARD) of 10/04/24, under Section C Cognitive Patterns, reflected on a brief interview for mental status (BIMS) score of 15 out of 15 which showed that the resident was cognitively intact.<br><br>On 11/06/24 at 11:19 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Regional Director of Operations (RDO). The surveyor notified the facility management of the above concerns and findings.<br><br>On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, Assistant Administrator (AA), and the Regional Infection Preventionist Nurse (RIPN). The DON stated that the facility was considered a regulated environment and acknowledged that meds should be properly stored.<br><br>A review of the Medication Storage Policy with a revised date of 10/2023 that was provided by the DON revealed:<br><br>Meds housed on our premises are stored in the pharmacy and/or med rooms according to the manufacturer's recommendations. All meds are stored in designated areas which are sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .<br><br>On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, RDO, Regional Clinical Operations, and the AA for the Exit Conference, and facility management did not provide any additional information.<br><br>49078<br><br>2. On 11/04/24 at 11:47 AM, the surveyor, in the presence of the med nurse on duty, inspected the med cart located on the 1 [NAME] Unit. The surveyor observed one (1) foil package of Budesonide (Pulmicort) nebulizer solution (a steroid inhalant liquid used with a mechanical nebulizer to treat asthma) with no date documented on the foil package when opened containing one (1) remaining vial. The surveyor also observed three (3) loose unidentified tablets in the bottom of the second drawer of the med cart. The surveyor asked the med nurse if she could identify the tablets. The med nurse stated she could not. The surveyor asked the med nurse if there was a date identifying when the foil package of Budesonide was opened. The med nurse stated there was no date visible. The med nurse disposed of the unidentified tablets and undated foil package in the presence of the surveyor.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The surveyor then accessed and inspected the med storage room (med room) and med refrigerator on the 1 [NAME] Unit in the presence of the med nurse. The surveyor observed a vial of influenza vaccine stored inside the refrigerator, and a refrigerator temperature log located on the outside of the refrigerator. The temperature log reflected documentation of internal temperatures once per day.<br><br>The surveyor, in the presence of the med nurse, inspected the med cart located on the Penthouse Unit. The surveyor also observed one (1) box of Ipratropium/Albuterol (DuoNeb) nebulizer solution (an inhalant liquid used with a mechanical nebulizer to treat asthma), which contained one (1) open foil packet with no date documented on the foil package when opened containing two (2) remaining vials. The surveyor also observed one (1) loose unidentified tablet in the bottom of the second drawer of the med cart. The surveyor asked the med nurse if she could identify the tablet. The med nurse stated she could not. The surveyor asked the med nurse if there was a date identifying when the foil package of DuoNeb was opened. The med nurse stated there was no date visible. The med nurse disposed of the unidentified tablet and undated foil package in the presence of the surveyor.<br><br>The surveyor, with the assistance of the Unit Manager, accessed and inspected the med room and med refrigerator located on the 2 South Unit. The surveyor observed a thermometer inside the med refrigerator that reflected a temperature of 30 degrees Fahrenheit. The surveyor also observed meds stored in the refrigerator. The surveyor observed a temperature log located on the outside of the refrigerator. The temperature log reflected an entry of 40 degrees Fahrenheit for 11/04/24.<br><br>The surveyor reviewed the manufacturer packaging and labeling for Ipratropium/Albuterol nebulizer solution. The product packaging and labeling reflected under Storage Conditions: Once removed from the foil pouch, the individual vials should be used within one week.<br><br>The surveyor reviewed the Budesonide manufacturer label and packaging which specified for Budesonide, once the foil pouch was opened, use ampules within (two) 2 weeks of opening.<br><br>The surveyor reviewed the CDC (Centers for Disease Control and Prevention) guidelines for vaccine storage which reflected for Monitoring Vaccine Temperatures, to ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using a TMD that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday).<br><br>On 11/06/24 at 11:45 AM, the surveyor, in the presence of the survey team, met with the LNHA, DON and RDO. The surveyor discussed the concerns with med storage.<br><br>On 11/06/24 at 01:11 PM, the surveyor conducted an interview with the facility Consultant Pharmacist (CP) by telephone. The CP stated they were covering for the regular CP who was out on leave. The surveyor asked the CP if DuoNeb and Budesonide foil packs should be dated when opened. The CP stated, yes, they should have a date when opened. The surveyor asked the CP what the appropriate temperature range for med storage refrigerator was. The CP stated normal refrigerator temperature should be between 36 to 46 degrees Fahrenheit. The surveyor asked the CP how the refrigerator temperature should be monitored when storing flu vaccines. The CP stated that they were unsure if it was once or twice a day, but twice a day would be a good practice.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/07/24 at 11:31 AM, the survey team met with the LNHA, DON, Regional Infection Preventionist Nurse (RIPN), and AA. The RIPN stated that educational in-services were implemented for dating of meds.<br><br>On 11/07/24 at 01:07 PM, the survey team met with the LNHA. The LNHA stated there is no further information to be provided.<br><br>A review of the facility's policy titled Medication Storage dated 9/2024 that was provided by the DON revealed:<br><br>The Policy reflected on the first line, Meds housed on our premises are stored in the pharmacy and/or med rooms according to the manufacturer's recommendations. Under line 4. Refrigerated Products, b. Temperatures are maintained within 36-46 degrees F. The policy did not reflect anything regarding loose, unlabled or unidentifiable meds.<br><br>NJAC 8:39-29.4(d)(g) |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>38327<br><br>Based on the interview and review of pertinent facility documentation, the facility failed to have the Infection Preventionist present for three (3) of three (3) quarterly Quality Assurance Performance Improvement (QAPI) meetings. This failure had the potential to affect all 156 residents who currently live in the facility.<br><br>The deficient practice was evidenced by the following:<br><br>On 10/29/24 at 11:02 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Assistant Administrator (AA), and the Registered Nurse/Unit Manager during an Entrance Conference meeting. The LNHA confirmed that day census (total number of residents) of 156. The LNHA stated that it was the Regional Infection Preventionist Nurse (RIPN) the facility's Infection Preventionist (IP), and the LNHA was unsure when the RIPN started to be the IP. The surveyor asked for the IP timeline since the last recertification (7/14/23), and the LNHA responded that he would get back to the surveyor.<br><br>On 11/06/24 at 01:48 PM, the Director of Nursing (DON) provided the last three-quarters of QAPI Attendance sheets and revealed the following:<br><br>QAPI Attendance:<br><br>5/29/24=the LNHA, Medical Director (MD), DON, Pharmacy Consultant (PC), and other Interdisciplinary Team (IDT) signed the QAPI Attendance sheet. There was no documented evidence in the sign-in sheet that the IP attended the meeting.<br><br>7/23/24=the LNHA, MD, DON, IDT, and vendor representatives signed the QAPI Attendance sheet. There was no documented evidence in the sign-in sheet that the IP attended the meeting.<br><br>10/22/24=the LNHA, MD, DON, IDT, and vendor representatives signed the QAPI Attendance sheet except for the IP. There was no documented evidence that the IP attended the meeting.<br><br>A review of the facility's QAPI Time and Date schedule revealed:<br><br>4/23/24=1st QAPI Report due (January 2024-March 2024)<br><br>7/23/24=2nd QAPI Report due (April 2024-June 2024)<br><br>10/23/24=3rd QAPI Report due (July 2024-September 2024)<br><br>01/25/25=4th QAPI Report due (October 2024-December 2024)<br><br>On 11/06/24 at 02:06 PM, the surveyor interviewed the RIPN who informed the surveyor that she recently assumed the IP position of the facility in October 2024. The surveyor asked for the IP timeline since the last recertification, signed job description, and certification for IP and she said she would get back to the surveyor.<br><br>(continued on next page) |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | At that same time, the surveyor asked the RIPN to confirm who was the IP in the submitted copies for QAPI attendance sheets on 5/29/24, 7/23/24, and 10/22/24. The RIPN confirmed that there were no IPs on the last three quarters' QAPI attendance sheets.<br><br>On 11/07/24 at 9:35 AM, two surveyors met with the LNHA for a QAPI interview. The surveyor notified the LNHA of the above findings and concerns that there were no IPs attended the last three quarters QAPI meeting which was confirmed as well by the RIPN as the attendance sheets were reviewed. The surveyor asked the LNHA who reported about infection control in the QAPI meeting in the absence of the IP, and the LNHA responded that it was the DON who reported about the facility's infection control. The LNHA acknowledged that the facility did not comply with the requirement that the designated IP should be dedicated solely to the IPCP (Infection Prevention Control Program).<br><br>A review of the facility's QAPI Plan that was provided by the LNHA did not include information that must be composed of at a minimum who the QAPI Committee was.<br><br>On 11/07/24 at 01:29 PM, the survey team met with the LNHA, DON, Regional Director of Operations, Regional Clinical Operations, and AA for the Exit conference. The facility did not provide additional information and did not refute the findings.<br><br>NJAC 8:39-33.1(b) |