STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whiting Gardens Rehabilitation and Nursing Center	3000 Hilltop Road Whiting, NJ 08759

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50919 Complaint # NJ00172931 Based on interviews, medical record review, and review of other pertinent facility documents on 09/25/2024, it was determined that the facility failed to notify a resident's power of attorney (POA) of a room change and document notification in the progress notes. The facility also failed to follow Mandatory Resident Rights. This deficient practice was identified for 1 of 1 resident (Resident # 1) reviewed for room changes. This deficient practice was evidence by the following: According to the Admission record (AR), Resident #1 was admitted to facility with diagnoses which included but were not limited to, Unspecified dementia (loss of thinking ability, memory, attention, logical reasoning, and other mental abilities), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Hypertension. A review of Resident #1's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 09/12/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. The MDS further revealed under section E that resident had physical and verbal behaviors towards others. A review of Resident #1's Progress Notes (PN) revealed on 09/29/23 that Resident #1 had a physical altercation with another resident that resulted in Resident #1's room to be changed. The PN further revealed no documentation of Resident #1's POA being notified of room change. During an interview with the surveyor on 09/25/2024 at 10:37 AM, the Licensed Practical Nurse Unit Manger (LPN UM #1) stated that when a resident's room must be changed, the family must be notified. LPN UM #1 further stated the resident's family had to be called prior to room change and resident should be moved after discussion with family. LPN UM #1 stated family notification for room changes were documented in the progress notes. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/25/2024 at 1:59 PM, in the presence of the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) stated that a resident's family was notified when room changes occurred. The LNHA further stated that after a resident's family was notified of a room change it was documented in the resident's progress notes. The LNHA stated that after a resident-to-resident altercation, the facility must make the decision to change a resident's room, but family notification must be documented in resident's progress notes. The DON and LNHA both stated that it was important to notify a resident's family of a room change because it was a resident's right. The DON brought the surveyor a copy of a facility document titled Subchapter 4: Mandatory Resident Rights on 09/25/2024 at 11:28 AM. The DON stated the facility did not have a policy on room changes and notification of room changes. Review of facility documentation titled Subchapter 4: Mandatory Resident Rights revealed under (a) Each resident shall be entitled to the following rights: 13. To receive notice of an intended transfer from one room to another within the facility or a change in roommate, including a right to an informal hearing with the administrator prior to the transfer as well as a written statement of the reasons for such transfer. NJAC 8:39-4.1 (a) (13)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50919 Complaint #: NJ00172931 Based on interviews, medical record review, and review of other pertinent facility documents on 09/25/2024, it was determined that the facility failed to develop and implement Care Plan (CP) interventions for a resident after a fall. The facility also failed to follow its policy titled Care Plans, Comprehensive Person-Centered. This deficient practice was identified for 1 of 3 residents (Resident # 3) reviewed for care plans. This deficient practice was evidence by the following: According to the Admission Record (AR), Resident # 3 was admitted to facility with diagnoses which included but were not limited to, Dementia (loss of thinking ability, memory, attention, logical reasoning, and other mental abilities), Unspecified Depression, and Unspecified Anxiety Disorder. A review of Resident # 3's most recent 5-day Admission Assessment Minimum Data Set (MDS), an assessment tool dated 08/26/2024 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident # 3's Progress Notes (PN) revealed that resident had a fall on 09/8/2024. A review of Resident #3's CP initiated on 07/26/2023 revealed under Focus, that Resident #3 had been identified to be at risk for falls and injury. Resident # 3's fall CP further revealed no interventions had been implemented or updated since 01/29/2024. During an interview with the surveyor on 09/25/2024 at 10:37 AM, the Licensed Practical Nurse Unit Manager (LPN UM #1) stated the care plans were updated as needed. LPN UM #1 stated UM was responsible for updating care plans. LPN UM #1 further stated the care plan should be updated as soon as an incident occurs. During an interview with the surveyor on 09/25/2024 at 1:35 PM, the LPN UM #1 stated that care plans should be updated within 24 hours of an incident including falls. LPN UM #1 further stated it was important to update the care plan after an incident, so that staff were aware of interventions that had to be implemented for the residents. LPN UM #1 confirmed Resident #3's care plan was not updated with interventions after the fall on 09/08/2024. LPN UM #1 stated Resident #3's care plan should have been updated after the fall occurred. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 09/25/2024 at 1:59 PM in the presence of the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) stated the UM and unit nurses were responsible for updating the care plans. The DON stated that the care plans were updated when there was a significant change, falls, or change in diet. The DON further stated that interventions were discussed during falls huddle meetings. The DON stated interventions would be discussed prior to implementing interventions. The DON stated the expectation was that the care plan should be updated within 48 hours after an incident occurred. The DON confirmed that Resident #3's fall care plan had no interventions added after the fall that occurred on 09/08/2024. Review of facility policy titled Care Plans, Comprehensive Person-Centered with an updated date of 10/2022 revealed under Policy Interpretation and Implementation, 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. when there has been a significant change in the resident's condition; c. when the resident has been readmitted to the facility from a hospital stay; d. at least quarterly, in conjunction with the required quarterly MDS assessment. NJAC 8:39-11.2 (e) (2)