STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegria at the Fountains	114 Hayes Mill Road Atco, NJ 08004

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 38680 Based on interview and record review, it was determined that the facility failed to complete the Quarterly Minimum Data Set assessment in a timely manner for 2 residents. This deficient practice was identified for 2 of 2 Residents (Residents #43 and #4) reviewed for Resident Assessment and was evidenced by the following: Resident #43 was admitted with diagnoses that included but was not limited to congestive heart failure and muscle weakness. On 6/26/2024, the surveyor reviewed the electronic medical record (EMR) for resident #43. The Quarterly Minimum Data Set (QMDS), an assessment tool completed every 3 months, revealed an Assessment Reference Date (ARD), a date used as the last day of a look-back period, of 5/26/2024. The EMR revealed that the QMDS for Resident #43 had been completed on 6/12/2024, 3 days late. Resident #4 was admitted with diagnoses that included but was not limited to dementia and anxiety. On 6/26/2024, the surveyor reviewed the EMR for Resident #4. The QMDS revealed an ARD of 5/24/2024. The EMR revealed that the QMDS for Resident #4 had been completed on 6/12/2024, 5 days late. During an interview with the surveyor on 6/27/2024 at 9:35 AM, the MDS Coordinator acknowledged that the QMDS's for Residents #43 and #4 were completed late. She stated it is important to have the MDS completed on time to be sure the resident is being assessed according to regulation. Review of the facility policy titled Resident Assessments with a revision date of March 2022 reflected that the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: (2) quarterly assessment. Review of the facility provided policy MDS Completion and Submission Timeframes revised October 2023 which reflected our facility will conduct and submit resident assessments in accordance with correct with current federal and state submission timeframes. NJAC 8:39-11.1

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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(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. 38079 43936 Based on observation, interview, record review, and review of pertinent facility documents, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's medical and nursing needs specifically by failing to implement a care plan for a.) the use of and refusal of bilateral (b/l) leg wraps for 1 of 1 resident (Resident #47) reviewed for skin conditions, b.) actual falls for 1 of 1 resident (Resident #19) reviewed for falls, and c.) an indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter or Urinary Tract Infection. The deficient practice was evidenced by the following: a.) On 06/25/2024 at 7:53 AM, Surveyor #1 observed Resident #47 lying in bed. Resident #47 stated that his/her legs blew up from water, went down and now are scaly. Resident #47 further stated that he/she told the staff to stop applying wraps to his/her legs because they [the wraps] were too tight. A review of Resident #47's Admission Record revealed that he/she had a diagnosis of edema. A review of Treatment Administration Record (TAR) dated June 2024, included an entry dated 06/07/2024, to apply [name redacted] wraps to b/l legs in the morning for edema and remove per schedule. The times plotted were to apply at 6:30 AM and remove at 6:30 PM. Documentation on the TAR indicated that on 06/08/2024, the wrap was not removed and that from 06/16/2024 through 06/21/2024, the wrap was not applied or removed. The TAR showed 2 or 9 which reflected either refused or see notes. A review of Resident #47's resident-centered, on-going Care Plan failed to include a focus area for the need of b/l leg wraps related to the diagnosis of edema, any focus area to address the resident's refusal of the leg wraps, any measurable goals, and any initial or revised interventions. b.) On 06/25/2024 at 8:05 AM, Surveyor #1 observed Resident #19 sleeping in his/her bed. The bed was in the low position. A review of Resident #19's Admission Record revealed that he/she had diagnoses which included but were not limited to; anxiety, mood disorder, and dementia. A review of Resident #19's Quarterly Minimum Data Set (MDS) an assessment tool to facilitate resident care dated 04/24/2024, revealed a Brief Interview of Mental Status (BIMS) of 10 out of 15 which indicated moderate cognitive impairment. Resident #19 was coded as requiring staff assistance for Activities of Daily Living. It was documented that the resident had no falls since Admission/Entry or Reentry. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided, Post Fall Evaluation dated 05/25/2024, indicated an un-witnessed fall in the resident's room which resulted in a skin tear on the left elbow. The Care Planning section included pain, pressure ulcer, risk for peripheral tissue perfusion, and wound management. There were no Care Plan indications for risk of falls or actual falls. A review of the facility provided, Post Fall Evaluation dated 06/17/2024, indicated an un-witnessed fall in the resident's room with no injury. The Care Planning section included pain, pressure ulcer, risk for ineffective peripheral tissue perfusion, and wound management. There were no Care Plan indications for risk of falls or actual falls. A review of Resident #19's resident-centered, on-going Care Plan included a focus area initiated 05/04/2024, high risk for falls r/t (related to) confusion this focus was not revised. The Goal was for the resident to be free of minor injury through the review date and was initiated on 07/03/2023 and revised on 08/16/2023. The care plan failed to initiate a focus area for either of the two actual falls, no goals, and no interventions for the first fall and no revisions after the second fall. c.) A review of Resident # 207's Admission Record revealed that he/she was admitted to the facility on at the end of May, 2024. A review of Resident # 207's Minimum Data Set (MDS; An assessment tool) dated 06/04/2024 revealed that he/she had an indwelling urinary catheter (tube inserted into the bladder to promote urination). A review of Resident # 207's Electronic Medical Record (EMR) under physician's orders revealed an order to provide catheter care. The orders also included an order to change the catheter drainage bag. A review of Resident # 207's EMR under diagnoses revealed a diagnoses of retention of urine (inability to empty the bladder completely). A review of Resident # 207's EMR under Care Plan revealed a focus that Resident # 207 was on Enhanced Barrier Precautions related to an indwelling catheter. The focus was initiated on 05/31/2024. The focus and interventions did not reveal any specific information regarding the indwelling urinary catheter or how to care for the indwelling urinary catheter. On 06/27/2024 at 10:05 AM, during an interview with Surveyor #1, the Licensed Practical Nurse (LPN) Unit Manager stated that a resident Care Plan should include areas such as Activities of Daily Living, refusal of medication or treatments, fall risk, and actual falls. She further stated that the Supervisors were responsible for initiating and updating Care Plans. On 06/27/2024 at 11:26 AM during an interview with Surveyor #2, Registered Nurse (RN) # 1 confirmed that Resident # 207 should have a care plan focus for the indwelling urinary catheter. RN # 1 stated, Yes, [he/she] is supposed to. Anyone with a [catheter] should have one mentioning the size at least. RN # 1 reviewed the care plan in the presence of the surveyor. RN # 1 confirmed Resident # 207 had one for enhanced precautions but not specifically for the catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 12:32 PM during an interview with Surveyor #2, the Director of Nursing (DON) replied, Yes, [he/she] should when asked if a resident with an indwelling urinary catheter should have a care plan focus for it. Secondly, the DON replied, We would document size and date it was inserted, care and how frequently it should be changed and quality of output. Further, she added the care plan should include any type of issues that may come when having a [catheter] inserted and education for the resident on proper care of the [catheter]. Lastly, the surveyor asked when should it [care plan] be added to the comprehensive if it was identified upon admission. The DON replied, On admission. On 06/28/2024 at 9:19 AM, during an interview with Surveyor #2, the DON stated that Resident # 207 was provided education directly, the care plan was updated and orders were reconciled regarding the catheter. At that time, the DON provided a copy of the care plan to the surveyor. The copy of the care plan revealed a focus, The resident has an indwelling foley catheter r/t urinary retention. The date initiated was 06/27/2024. On 06/28/2024 at 9:21 AM, the DON in the presence of the survey team, stated that upon being made aware by the surveyors, Resident #47's Care Plan was updated. The DON further stated that there would be a fall meeting daily and acknowledged that there was no Care Plan for Resident #19's two actual falls. The DON established that she was responsible to ensure that after a fall meeting, the nurses were implementing Care Plans with interventions. The Licensed Nursing Home Administrator (LNHA) was also present and stated that there was no documentation that Resident #47's physician or representative was made aware of the refusal of the b/l leg wraps. The LNHA stated, there was no documentation, and we have to work on our documentation. She further stated that education was being provided regarding family and physicians being notified. A review of the facility policy titled, Care Plans, Comprehensive Person-Centered revised March 2022 revealed under Policy Interpretation and Implementation that, 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. A review of the facility policy, Requesting, Refusing and/or Discontinuing Care or Treatment revised 02/2021, included but was not limited to; Policy Interpretation and Implementation: 1. Resident . are informed . of: a. the care that will be furnished . based on his/her assessment and plan of care. A review of the facility policy, Assessing Falls and Their Causes revised 03/2018, included but was not limited to; Preparation: 1. Review the resident's care plan to assess for any special needs of the resident. Documentation: . the following information should be recorded in the resident's medical record: 13. Interventions . 16. Appropriate interventions taken to prevent future falls. S 8:39-11.2 (e)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38079 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide education to a resident who was refusing a treatment and to notify the resident's physician and family. This deficient practice was identified for 1 of 1 residents (Resident #47) reviewed for skin conditions. The deficient practice was evidenced as follows: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of 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. On 06/25/2024 at 7:53 AM, the surveyor observed Resident #47 lying in bed with a sheet and blanket over him/her. At that time, Resident #47 stated that his/her legs blew up from water, went down and now are scaly. The resident further stated that the staff had them wrapped but it was too tight, so he/she told them [the staff] to stop wrapping their legs. A review Resident #47's Admission Record revealed that he/she had diagnoses which included but were not limited to; cellulitis (a bacterial infection of the skin which may cause swelling), localized edema, gout, and local infection of the skin and subcutaneous tissue. A review of the Minimum Data Set (MDS) an assessment tool used to facilitate care dated 05/06/2024, included but was not limited to; a Brief Interview for Mental Status (BIMS) of 09 out of 15 which indicated moderate cognitive impairment. A review of the Treatment Administration Record (TAR) for June 2024, included the order dated 06/07/2024, to apply [name redacted] wraps to bilateral legs in the morning for edema and remove per schedule. The times plotted were to apply at 6:30 AM and remove at 6:30 PM. The TAR identified that on 06/08/2024, the wrap was not removed; from 06/16/2024 through 06/21/2024, the wrap was not applied or removed. The correlating codes on the TAR were either 2 or 9 which reflected either drug refused or see notes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Progress Notes (PN) revealed that on 06/16/2024, the Licensed Practical Nurse (LPN) documented the wrap was not on the resident's legs. The PN dated 06/19/2024, documented by the LPN that there were no wraps on the resident's legs. A Physician's PN dated 06/21/2024, documented continue . wraps. An LPN PN dated 06/21/2024, documented refused to have his/her legs wrapped this morning, no wraps to remove. A Registered Nurse (RN) PN dated 06/25/2024, documented resident refused leg wraps. A Physician's PN dated 06/25/2024, documented the resident was declining the wraps per staff. There were no PN's that the physician was made aware prior to 06/25/2024, that the family representative was made aware, or that the resident was educated regarding the risks vs. benefits of the wraps. On 06/27/2024 at 9:56 AM, the LPN on the unit stated that if a resident were to refuse a treatment, the process was to notify the physician for orders. On 06/27/2024 at 10:05 AM, the LPN Unit Manager stated the process for a resident refusing a treatment would be to educate the resident, call the physician, document in the medical record. A review of the facility policy, Requesting, Refusing and/or Discontinuing Care or Treatment revised 02/2021, included Policy Interpretation and Implementation 5. If a resident/representative . refuses care or treatment, an appropriate member of the interdisciplinary team (IDT) will meet with the resident/representative to: a. determines why he or she is requesting, refusing or discontinuing .; c. discuss the potential outcomes or consequences of the decision. 6. b. the IDT will assess the resident's needs and offer . alternative treatments, if available and pertinent, while continuing to provide other services outlined in the care plan. 8. Detailed information relating to . the refusal . are documented in the resident's medical record. 9. Documentation pertaining to a resident's . refusal of treatment includes at least the following: a. the date and time the . treatment was attempted; b. the type of care or treatment; c. the resident's . stated reason . for the refusal; d. the name of the person who attempted to administer . the treatment; e. that the resident was informed . of the purpose of the treatment and the potential outcome of not receiving the medication/or treatment; f. the resident's condition and any adverse effects due to the request; g. the date and time the practitioner was notified . the practitioner's response; h. all other pertinent observations; and i. the signature and title of the person recording the data. NJAC 8:39-27.1(a)(b)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38680 Based on observation, interview, and record review, it was determined that the facility failed to A. maintain accurate accountability of a controlled medication and B. properly acquire a controlled drug (Xanax) that staff borrowed for an unsampled resident. This deficient practice was identified for 1 of 2 medication carts and was evidenced by the following: A. On 6/25/2024 at 11:03 AM, the surveyor reviewed Cart 1 with the Licensed Practical Nurse (LPN). The Individual Patient Controlled Substance Administration (IPCSA) record for unsampled Resident # 154 reflected that there were 29 Xanax (a drug used to treat anxiety) 0.5mg (milligram) pills available. The LPN and the surveyor reviewed the corresponding medication card (bingo card) for the Xanax 0.5mg which reflected there were 28 pills available. The LPN acknowledged that there should be 29 Xanax pills. On 6/25/24 at 11:03 AM, the surveyor reviewed the June 2024 Medication Administration Record for Resident #154 with the LPN. There was no documentation that the Xanax 0.5mg was administered to the resident. During an interview with the surveyor on 6/25/2024 at 11:08 AM, the Unit Manager/Charge Nurse (UM/CN) stated that there should be 29 Xanax pills. During an interview with the surveyor on 6/25/2024 at 11:38 AM, the LPN stated that she counted the narcotics in the cart by herself. She stated she must have missed the missing Xanax. During an interview with the surveyor on 6/25/2024 at 11:47 AM, the Director of Nursing (DON) stated that the IPCSA should be signed out when administering medication. On 6/26/2024 at 9:30 AM the DON stated that after an audit, she found that the extra Xanax was administered to Resident #154 however was not signed out on the IPSCA. A review of the facility policy titled, Controlled Substances, revised November 2022 reflected: 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between the loss/diversion and detection/follow up. B. On 6/25/2024 at 11:03 AM, the surveyor reviewed Cart 1 with the Licensed Practical Nurse (LPN). The Individual Patient Controlled Substance Administration (IPCSA) record for unsampled Resident # 154 reflected that on 6/24/2024 at 9PM Xanax 0.5mg was borrowed for unsampled Resident #1. On 6/25/2024 at 11:25 AM, the surveyor and the Registered Nurse #1 reviewed the Medication Administration Record (MAR) for Resident #1. The MAR reflected that Resident #1 was administered Xanax on 6/24/2024 at 9:03 PM which corresponds to the IPCSA of Resident #154. When asked at that time if medication should be borrowed, the UN/CN and RN#1 stated, No. During an interview with the surveyor at 6/25/2024 at 11:47 AM, the DON stated that the nurses should not borrow narcotics if the medication is not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Controlled Substances, revised November 2022 reflected 4. An individual resident-controlled substance record is made for each resident who will be receiving a controlled substance. This record contains: a. name of resident . NJAC: 8:39-29.7(k), 29.7(c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49712 Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 06/25/2024 from 07:30 AM to 07:50 AM the surveyor, accompanied by the Food Service Assistant Director (FSAD), observed the following in the kitchen: 1. The meat slicer was observed uncovered with pink food scraps on it. The FSAD said, We just finished cutting ham for breakfast, and haven't had time to clean it yet. 2. In the walk-in refrigerator an open package of hard-boiled eggs was wrapped in plastic wrap with no open or use by date label. The FSAD removed them from the refrigerator and stated, It should have a label on it. 3. In the freezer, an unidentified frozen food was wrapped in plastic wrap without a label or date. The FSAD removed the food from the Freezer and stated, Yes, this should be labeled also. 4. In the dry storage area, a dented can of baked beans was observed on the can rack. The FSAD said it should not have been there and pulled it from the rack. A review of an undated facility policy titled Labeling and Dating Inservice, revealed under Importance of labeling and dating that Proper labeling and dating ensure that all foods are stored, rotated, and utilized in a First IN First Out (FIFO) manner. This will minimize waste and ensure that items that are passed their due date are discarded. Also revealed under Guidelines for Labeling and Dating that Food labels must include: the food name, the date of preparation receipt removal from freezer and, the use by date outlined in attached guidelines. N.J.A.C. 8:39-17.2(g)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49712 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to ensure documentation in the resident's medical record of the information provided regarding the benefits and risks of immunization and the administration or the refusal of the vaccine, specifically the influenza vaccination (vaccine used to prevent influenza). The deficient practice was identified for 1 of 5 resident's reviewed for immunizations, (Resident #45). This deficient practice was evidenced by the following: According to the Admission Record, Resident #45 was admitted to the facility with diagnoses including but not limited to: Diabetes Mellitus (DM) (a disease of inadequate control of blood levels of glucose) and Hypertension (high blood pressure). A Review of Resident #45's admission Minimum Data Set (MDS) an assessment tool used to facilitate care, dated 02/13/2024 revealed a Brief Interview for Mental status score of 14/15, indicating Resident #45 was cognitively intact. Section 0250 indicated Resident #45's influenza vaccine was not received. The MDS further revealed that the reason the vaccine was not given was not assessed. During an interview with the surveyor on 06/27/2024 at 09:32 AM, the Director of Nursing (DON) said they had requested his files from Veterans Affairs that morning. The facility could not produce a consent or refusal form for the influenza vaccine. During an interview with the surveyor on 06/27/2024 at 12:33 PM, The DON stated, yes when asked if Resident #45's Influenza vaccine should have been assessed on admission. A review of a facility provided policy titled Influenza Vaccine, revealed under the Policy Interpretation and Implementation section, that 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. A review of a facility provided policy titled Vaccination of Residents revealed under the Policy Interpretation and Implementation section, that 3. All new Residents shall be assessed for current vaccination status upon admission. N.J.A.C. 8:39-19.4 (h)