STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315304	A. Building B. Wing	12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Haven Rehab and Nursing Center	350 Oxford Road Oxford, NJ 07863

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 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. 46889 Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan (CP) that included anti-anxiety medication. This deficient practice was identified for 1 of 12 residents (Resident #6) reviewed for comprehensive person-centered CP. This deficient practice was evidenced by the following: On 12/17/24 at 10:10 AM, the surveyor observed Resident #6 seated in their wheelchair. On 12/19/24 at 12:03 PM, the surveyor reviewed the hybrid (paper and electronic) medical records of Resident #6, which revealed the following: A review of the Admission Record (an admission summary) reflected that Resident #6 was admitted to the facility with diagnoses that included but were not limited to unspecified Dementia (loss of memory). A review of the quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated 11/5/24, reflected that the resident had a Brief Interview for Mental Status score of 6 out of 15, indicating severely impaired cognition. A review of the December 2024 Order Summary Report for Resident #6 reflected a Physician Order (PO) dated 10/30/24 for Lorazepam Concentrate (an anti-anxiety medication) 2 mg (milligram)/ml. (milliliter) give 0. 25 ml sublingually (administered under the tongue) every 4 hours as needed . A review of Resident #6's November and December 2024 electronic Medication Administration Record (eMAR) revealed the above PO were administered to the resident on 11/23/24 at 8:57 AM and 12/11/24 at 12:40 AM. A review of the progress notes dated 11/23/2024 at 10:12 AM revealed that Resident #6 was given Lorazepam according to the PO due to increased shortness of breath. A review of Resident #6's CP did not reflect a CP for the use of anti-anxiety medication. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the hospice records titled Interdisciplinary Group Meeting, dated 11/7/24 under current CP did not reflect any CP for the use of anti-anxiety medication. On 12/20/24 at 11:22 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the above concern. The LPN stated that if a resident was on an anti-anxiety medication, it must be addressed in the resident's CP. On 12/20/24 at 11:29 AM, the surveyor conducted a telephone interview with the Clinical Director/Registered Nurse (CD/RN) for the hospice company who did not provide any information regarding the CP for the use of anti-anxiety medication. On 12/23/24 at 1:10 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to discuss the above concern. There was no additional information provided. A review of the policy titled Hospice Services with a reviewed date in May 2024 stated under Procedure: 14. Each resident's plan of care will include an integrate both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practical physical, mental, and psychological well-being. NJAC 8:39-11.2(e)(2)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37791 Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities in the resident's medical record to the facility staff and attending physician. This deficient practice was identified for one (1) of fourteen (14) residents reviewed, (Resident #40) for medication management and was evidenced by the following: On 12/18/24 at 11:45AM, the surveyor observed Resident #40 in the facility activity room. The resident was seated in a wheelchair and was observed coloring pictures. The surveyor reviewed Resident #40's medical records. A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; gastrostomy status (refers to the presence of a surgical opening into the stomach, which allows for nutritional support of gastric decompression), neurocognitive disorder with Lewy bodies (type of dementia characterized by a decline in thinking abilities, including attention, visual perception, and executive function) and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete painful blockage). A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care dated 11/22/24, reflected that the resident's cognitive skills for daily decision-making score was 0 out of 15, which indicated that the resident's cognition was severely impaired. A review of the December 2024 Order Summary Report (physician's order sheet) (OSR) revealed a physician's order (PO) dated 10/11/24, for Donepezil tablet 10 mg (milligrams) by mouth at bedtime related to dementia in other diseases classified elsewhere. The December 2024 OSR also revealed a PO dated 5/12/23 for NPO (not by mouth) diet NPO texture, receives Bolus Feeding. A review of the November 2024 and the December 2024 electronic medication administration record (eMAR) revealed a PO dated 10/11/24, for Donepezil tablet 10 mg by mouth at bedtime related to dementia in other diseases classified elsewhere. Donepezil was scheduled to be administered every day at 20:00 (8:00 PM). A review of the CP's evaluation reports dated 11/1/24 and 12/3/24 indicated that the CP reviewed the medication regimen for Resident #40 with no new medication recommendations indicated. On 12/18/24 at 12:50 PM, the surveyor in the presence of the Registered Nurse (RN)/ Unit Manager (UM) reviewed Resident#40's PO. At that time, the RN/UM acknowledged that Donepezil medication was ordered by the physician to be given by mouth but also acknowledged that the resident received their medications via a g-tube (gastrostomy tube). The RN/UM further stated that the CP should have identified the discrepancy during their monthly medication review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 1:00 PM, the surveyor met with the Licensed Nursing Home Administrator and Director of Nursing to discuss the above concerns. There was no additional information provided. On 12/20/24 at 12:15 PM, the surveyor conducted a telephone interview with the CP who acknowledged that she reviewed the residents' medication regimen monthly. The CP also acknowledged that part of her reviews was to ensure that the medications for the residents were being administered via the correct route. The CP further acknowledged that Resident #40 was NPO and received medications via a g-tube. The CP stated the facility should have been notified regarding the PO for Donepezil administration route discrepancy. A review of the facility's policy for Administrative Policy and Procedures dated 07/31/24, which was provided by the DON included the following: The Consultant Pharmacist shall identify, document, and report actual and potential irregularities for review and action to the Director of Nursing and or/designee, Administrator, Medical Director and physicians (where appropriate). The physician's recommendations will be communicated to the Director of Nursing and/or Designee for distribution and action by the attending physician via email, fax (or both). NJAC 8:39-29.3

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 Based on observation, interview, and record review, it was determined that the facility failed to have physician progress notes (PPN) readily accessible in the facility. This deficient practice was identified for 7 of 12 residents reviewed, (Resident #207, #5, #48, #16, #21, #6, #45) and was evidenced by the following. 1. On 12/17/24 at 10:42 AM, the surveyor observed Resident #207 in the dayroom watching television. The resident stated to the surveyor they have seen their primary physician (PP) a few times since their admission. A review of Resident #207's Face sheet (FS) (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to multiple sclerosis, type 2 diabetes, peripheral vascular disease, and heart failure. A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate care management dated 12/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated that resident was cognitively intact. On 12/18/24 at 12:01 PM, the surveyor reviewed the hybrid medical records (HMR), (combination of the physical and electronic chart) and did not observe any PPN documentation. 2. On 12/17/24 at 11:20 AM, the surveyor observed Resident #5 in the dayroom watching television. The surveyor interviewed Resident #5 who stated they can't recall when they were seen by their PP. A review of Resident #5 FS revealed that the resident was admitted to the facility with diagnoses that included but were not limited to generalized anxiety disorder, anemia, type 2 diabetes, and hyperlipidemia. A review of the Annual Minimum Data Set (A/MDS), an assessment tool used to facilitate care management dated 11/8/24, indicated a BIMS score of 15 out of 15 which indicated that resident was cognitively intact. On 12/18/24 at 12:05 PM, the surveyor reviewed the HMR and did not observe any PPN documentation. 3. On 12/17/24 11:25 AM, the surveyor observed Resident #48 in the dayroom seated in the wheelchair with eyes closed. A review of Resident #48 FS revealed that the resident was admitted to the facility with diagnoses that included but were not limited to dementia, Parkinson's disease, insomnia, and generalized anxiety. A review of the Q/MDS, an assessment tool used to facilitate care management dated 11/28/24, indicated a BIMS score of 15 out of 15 which indicated that resident was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/18/24 at 12:10 PM, the surveyor reviewed the HMR and did not observe any PPN documentation. 4. On 12/17/24 at 12:00 PM, the surveyor observed Resident #16 in the dayroom seated in their wheelchair. A review of Resident #16 FS revealed that the resident was admitted to the facility with diagnoses that included but were not limited to dementia cognitive communication deficit, protein-calorie malnutrition, and glaucoma. A review of the Q/MDS, an assessment tool used to facilitate care management dated 10/3/24, indicated a BIMS score of 00 out of 15 which indicated that resident had severely impaired cognition. On 12/18/24 at 12:20 PM, the surveyor reviewed the HMR and did not observe any PPN documentation. 46889 5. On 12/17/24 at 9:50 AM, the surveyor observed Resident #21 in bed watching television. Resident #21 was able to answer the surveyor's inquiry. On 12/18/24 at 11:42 AM, the surveyor reviewed the HMR of Resident #21, which revealed the following: A review of the FS revealed that Resident #21 was admitted with diagnoses that included but were not limited to dementia (loss of memory). A review of the Q/MDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 8 out of 15, which indicated that the resident had moderately impaired cognition. On 12/18/24 at 1:22 PM, the surveyor reviewed the HMR and did not observe any PPN documentation. 6. On 12/17/24 at 10:10 AM, the surveyor observed Resident #6 seated in their wheelchair. On 12/19/24 at 12:03 PM, the surveyor reviewed the HMR of Resident #6, which revealed the following: A review of Resident #6's FS revealed that the resident was admitted to the facility with diagnoses that included but were not limited to unspecified Dementia (loss of memory). A review of the Q/MDS, dated [DATE], reflected that the resident had a BIMS score of 6 out of 15 which indicated that the resident severely impaired cognition. On 12/18/24 at 1:22 PM, the surveyor reviewed the HMR and did not observe any PPN documentation. 7. On 12/17/24 at 9:40 AM, the surveyor observed Resident #45 awake and was seated in the wheelchair inside the dayroom. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/17/24 at 11:54 AM, the surveyor reviewed the HMR of Resident #45, which revealed the following: A review of Resident #45's FS revealed that the resident was admitted to the facility with diagnoses that included but were not limited to diabetes mellitus (high blood sugar). A review of the A/MDS, dated [DATE], reflected that Resident #45 had a BIMS score of 15 out of 15 which indicated that the resident had intact cognition. On 12/18/24 at 1:22 PM, the surveyor reviewed the HMR and did not observe any PPN documentation. On 12/18/24 at 12:41 PM, the surveyor interviewed the PP, who stated he is the PP for all the residents in the facility. The PP also stated that he would come in the facility every Wednesday and most weekends. The PP further stated the resident's PPN were not in the facility's electronic charting system, but were in a separate electronic system in which only the PP would have access to them. The PP acknowledged that the PPN's were not inside resident's physical chart. On 12/18/24 at 1:01 PM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM) who confirmed that the facility including the nursing staff does not have access to the resident's PPN and there were no PPN's observed in the physical chart. On 12/18/24 at 1:15 PM, the Director or Nursing (DON) provided the surveyor with a facility policy titled, Physician Service policy and Procedure with a revised date of 7/24. Under the policy and implementation section it states, 3. Physician orders and progress notes shall be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. On 12/19/24 at 1:12 PM, the survey team met with the DON and Director of Operations (DOO) and reviewed the above concerns. The DON stated, they were aware of the concern. No further information was provided. NJAC 8:39-35.2 (d)(5)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46889 Based on observation, interview, record reviews, it was determined that the facility failed to follow a.) appropriate infection control practices for handling and storing clean clothes observed in the laundry room and b.) the policy and procedure of the facility's Water Management Program to prevent the growth of Legionella (a waterborne pathogen). This deficient practice was evidenced by the following: 1. On 12/19/24 at 9:35 AM, the surveyor together with the facility's Infection Preventionist (IP) toured the laundry room. The surveyor observed a rack of hangers of clothes covered with a clean blanket touching the laundry room floor. The surveyor interviewed the Housekeeping Manager (HM) who stated those clothes clean. The HM also stated the clothes were washed and brought to the residents who would need them. The HM acknowledged to the surveyor that the clean clothes should not touch the floor. On 12/19/24 at 10:03 AM, the surveyor interviewed the IP regarding the above concern. The IP stated that the clothes should not touch the ground because they were clean already. On 12/19/24 at 10:45 AM, the Director of Nursing (DON) provided a policy titled The Laundry Process, but it did not address handling clean clothes after washing. On 12/19/24 at 1:13 PM, the survey team met with the DON and Director of Operations regarding the above concern. The DON stated that those clothes were unlabeled and once the owner was found, they would give the clothes back. The DON also stated the clothes have been on the rack for 30 days; and they were lost-and-found clothes. 2. On 12/17/24 at 10:15 AM, during the entrance conference with the Licensed Nursing Home Administrator (LNHA) and the DON, the surveyor requested the facility's water management program and evidence of monitoring. On 12/19/24 at 9:25 AM, the surveyor interviewed the IP. The surveyor asked if there had been a case of resident diagnosed with Legionella or other waterborne pathogen illness in the facility, the IP stated that there had not been any cases reported. On 12/20/24 at 12:56 PM, the surveyor interviewed the LNHA, who stated the facility hired an outside company for the well water (water from a well, which is a hole dug into the ground to access groundwater) system. The LNHA stated they couldn't find the last water testing from the previous company. On 12/23/24 at 1:20 PM, the survey team met with the LNHA to discuss the above concern. The LNHA stated they do not have records for their water management. The LNHA also stated that the facility had no water management plan. A review of the records provided by the Director of Maintenance (DM) titled Certificate of Analysis, dated December 5, 2024, and November 11, 2024, indicated the facility monitored the chlorine and coliform levels. There was no documented evidence for the monitoring of waterborne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy titled Water Management Plan, with a reviewed date of November 15, 2023, included the following: Policy: It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens . NJAC 8:39 - 19.4(i) NJAC 8:39-19.1